IPAL

Annual Report 1973

Assessment and Placement Service of the Hamilton District Health Council

TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

ASSESSMENT & PLACEMENT SERVICE STAFF

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(Mrs) S. Cameron, Assessment Consultant (Sept'71-Jan'73)
(Mrs) M. Davidson, Assessment Consultant
(Ms) L. Geres, Assessment Consultant
(Ms) J. McTavish, Assessment Consultant
(Ms) F. Hanson, Information Coordinator & Data Analyst
(Miss) K. Downes, Secretary
(Mrs) E. Turner, Secretary

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SECOND ANNUAL REPORT

- SEPTEMBER 1, 1972 - AUGUST 31, 1973 -

of the

ASSESSMENT AND PLACEMENT SERVICE

of the

HAMILTON DISTRICT HEALTH COUNCIL

PART I: INTRODUCTION:

Aims & Purposes

The Assessment & Placement Service (A.P.S.) was established under the Hamilton District Health Council and officially began its operation in September 1971. The first annual report outlined the problems identified and some of the remedial action taken. This report covers the second year which began September 1, 1972 and ended August 31, 1973.

The term "Assessment" used by this service means the carrying out of an evaluation of an applicant's needs, following the format of a specially designed form called the Referral Form.

The term "Placement" used by this service means the involvement of the applicant in a new program, or a modification of the existing one, as recommended by A.P.S. on the basis of the applicant's assessed needs. It does not necessarily mean admission to institutional care and frequently means remaining or returning to community living. This may or may not require transfer of the applicant to a new locality.

The purposes of A.P.S. are:

(a) to help physicians and other health professionals assess the social, economic, health characteristics and needs of people of any age who are disabled by on-going physical or psychological problems, using the Referral Form which obtains a broad range of information;

(b) to identify treatment or support programs that can meet these needs and recommend their use to the referring professionals, the applicant, and his family;

(c) to identify gaps or deficiencies in health care delivery to disabled or handicapped people; to work with staff in existing programs, and to assist in policy development by referral to Health Council;

(d) to provide a means of transmitting information about programs or an applicant's needs so that health professionals are better informed, and resources are used appropriately;

(e) to collect data necessary to facilitate health planning;

(f) to provide information on the needs of disabled people for further study and research.

The initial staffing has been increased slightly in consequence of the growth of the service. The present staff consists of, a part-time Medical Director; an administrator; three assessment consultants; a data analyst; and two secretaries.

Referral Process

The Referral Form has been revised and is believed to provide an accurate picture on which to recommend an appropriate program. The referral form is in two sections. Section "A" enquires about social aspects, physical and mental functioning, and may be completed by nursing and/or social service professionals. Section "B" enquires about medical aspects, i.e. diagnosis, treatments, prognosis, and is completed by the attending physician.

Several features of the referral form should be noted. The form guides the health professionals to record precise answers, which is particularly important in the areas of self care and mental competence. There is an overlap in the information requested from the physician and from other professionals and further enquiry is made if there are inconsistencies, if the diagnosis appears inaccurate, or if there are important ommissions. This audit of medical care is important to be sure no aspect of care is neglected. The information on the form enables A.P.S. to identify the appropriate program and to discuss it with the program staff, if necessary, to be sure the applicant will be accepted when the recommendation is made. This prevents the frustrating experience of a person going through various admissions procedures and being rejected in the end. It has also been possible to encourage a program to modify admission criteria for an applicant whose needs could not be met elsewhere.

The referral procedure is well established. If the applicant is in the community when A.P.S. is contacted for assistance section B of the referral form is sent to the family physician, and section A to another involved health professional, for example V.O.N. or Visiting Homemaker. If no type of support services or

professional is involved, a Public Health Nurse will visit, on request, and complete Section "A" of the referral form. If the applicant is in hospital the Social Service Department will see to completion of the assessment form and submit it to A.P.S.

The referral is assigned to an assessment consultant who with this information may recommend a known program with a vacancy, or seek an appropriate program. This may be in an institution, such as a chronic disease hospital, nursing home, or Home for the Aged, or it may be a community-based program.

Letters containing the recommendations are sent to those involved with the referral. After a placement is carried out, the A.P.S. consultant follows-up with a telephone call one month later to enquire whether the placement has worked out satisfactorily. If it is found after placement that the applicant cannot be managed or is inappropriate for the program, the A.P.S. would seek another placement. This method of follow-up is not entirely reliable but time and staffing do not permit more at present.

Planning and Coordinating Activities

In pursuing the objective of identifying gaps or deficiencies in the health care system, A.P.S. staff met with a variety of health professionals, students and others involved in both institutions and the community. The number of people waiting for placement into chronic hospital facilities or nursing homes, especially when waiting in acute care hospitals, is a constant problem. The number of beds for acute care, chronic hospital care, and nursing home care in Ontario is controlled by the Ministry of Health and cannot be modified without their permission. The A.P.S. maintains an accurate list containing the name of each applicant, his present location, and the program he is waiting for. If changes occur in an applicant's health status his placement recommendation can be amended.

A number of meetings were held with the Admissions & Discharge committees of the acute care hospitals to discuss the problem and explore possible solutions. On a few occasions A.P.S. discovered that an ill person had been sent home, which had placed a great strain on themselves and their families. Also a few instances were noted of patients being transferred from an acute care hospital to an extended care facility in a moribund

condition. Through the Social Service Departments of the hospitals, guidelines were worked out stating that no person would be considered for transfer if death were likely to occur in two weeks, and similarily, if at the time of transfer death were likely to occur the transfer would be delayed or cancelled.

The problem of adequate follow-up and support of persons discharged from the psychiatric hospital, with residual handicaps, was discussed with various psychiatric community teams, and staff of the mental hospital. The role of A.P.S. in this complex issue is gradually being broadened and clarified.

There were difficulties with handicapped people being accepted by certain Homes for the Aged and nursing homes. Meetings with the administrative and professional staffs resulted in better understanding of the community need for residential care, and the difficulties institutions face managing severely disabled residents. A.P.S. staff now regularly attend the admissions committee meeting of a large Home for the Aged. In addition, extended care facilities are encouraged to refer people they feel unable to manage adequately, due to increased degree of debility.

A research project was initiated to examine the queue of people waiting for ward accommodation in nursing homes in the Hamilton district. Information from such a study would be helpful in forecasting the effect of increasing or decreasing the number of beds for a specific level of care upon the whole system.

Effort was devoted to developing a follow-up form to define accurately the problem areas in a patient's management and the status anticipated at the date of follow-up. This follow-up form is suitable for persons with any type of disability - physical or psychological.

A.P.S. has been involved with the community services. Staff has been working closely with the V.O.N. and presently one of their nurses is based in a Day Centre program for the aged, located in an area chronic hospital. This nurse helps the Centre to reach into the community and to support and maintain people there.

A number of short term projects to promote activation programs in nursing homes, largely organized by students and young people, were supported administratively by A.P.S. Meetings were held with several established agencies to develop a proposal to set up an on-going activation program that would include and utilize volunteer help.

Through the Ministry of Health's Nursing Home Consultant, information was received on the educational needs of professional nurses working in nursing homes, and steps taken to identify these needs so they could be met by appropriate continuing education.

Help was given to various organizations planning new or expanded social services, by identifying needs and existing resources. A.P.S. data was retrieved to help one of the chronic care facilities visualize its present load in caring for young severely disabled people, and in trying to forecast the future need.

There were a number of meetings with students in medicine, hospital administration and related disciplines to explain the purposes of A.P.S., and aspects of regional planning and health care delivery. Visitors were received from various areas of Ontario, including Ministry of Health officials; and from health professionals in other provinces and countries, interested in developing a similar service.

PART II: ANALYSIS OF THE PROCESS OF ASSESSING AND PLACING APPLICANTS:

Caseload

During the period September 1, 1972 to August 31, 1973, A.P.S. was involved in 2783 cases. This includes 291 cases carried over from the previous year. (i.e. 10% of the total case load) Sixty-seven percent of the total caseload were new referrals and 22% were re-referrals (that is - the case had been initiated at least once prior to this referral). Half of the re-referrals had at least two referrals in the '72-'73 period.

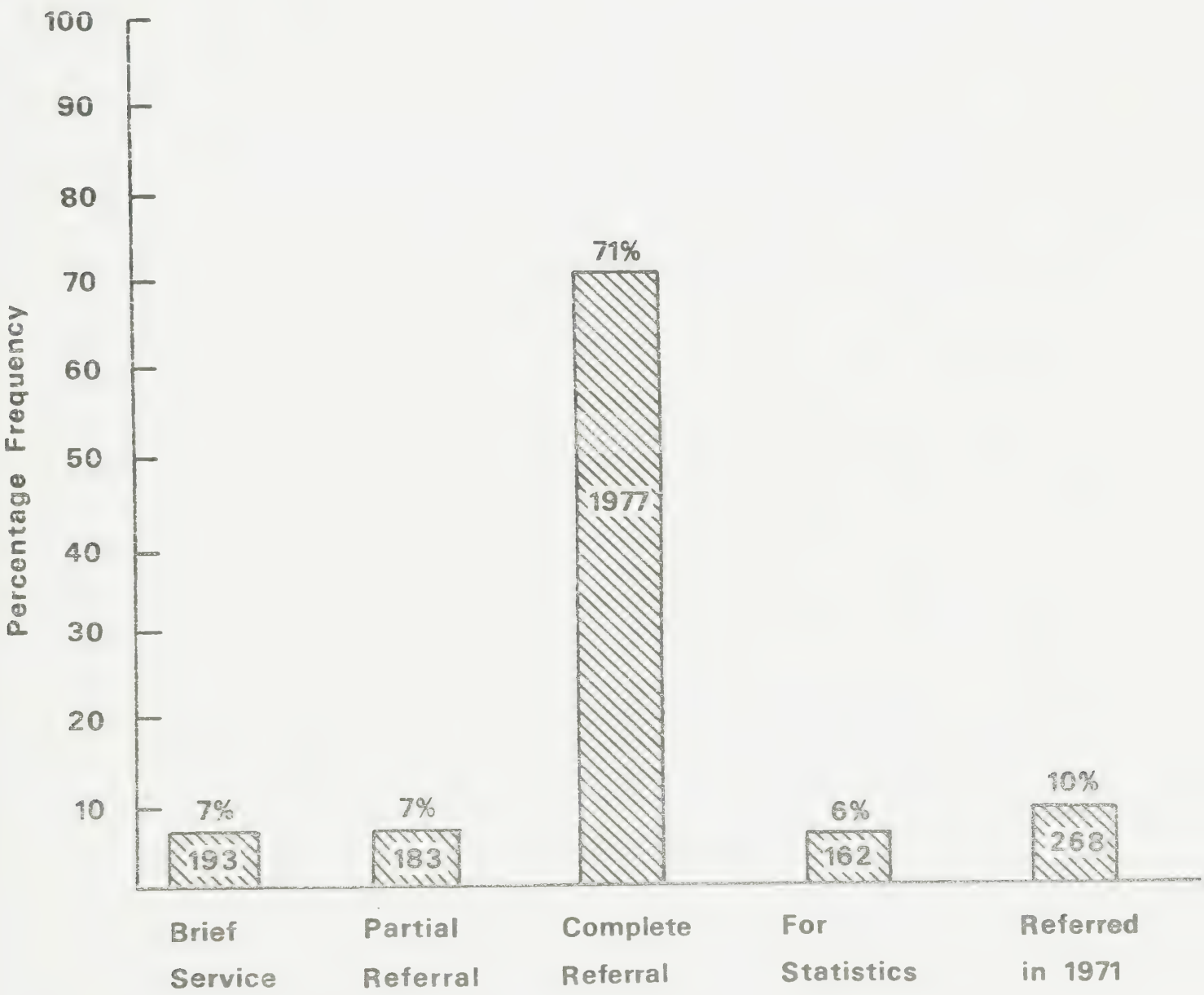
A referral to A.P.S. can be initiated by a telephone call, or receipt of part of a completed referral form. (Agencies which frequently make referrals to A.P.S. have a supply of referral forms on hand). If, by the end of the coding year, nothing more than a contact had been made, the type of service provided would be called "Brief Service". A.P.S. may have provided just information to these callers; they may have changed their minds about A.P.S. involvement, died or moved somewhere on their own after the contact; or the case may still be in process. A.P.S. handled 193 such cases, or 7% of our total caseload. For reasons similar to those listed above, A.P.S. may have only one part of a completed referral form on a person - either the Social-Nursing section or the Medical section. A.P.S. was involved in 183 cases with partially completed forms which constituted 7% of the total caseload. Seventy-one percent had completed referral forms. For these cases an A.P.S. assessment consultant would make recommendations as to the most appropriate level of care available, and would attempt to effect placement in that level of care. Some cases are referred "after-the-fact" - that is, after placement has been effected - for A.P.S. information only. The A.P.S. staff do conference these cases and inform the referring agency whether or not they agree with the acutal placement. A.P.S. was involved in 162 of these cases. Ten percent of the cases were coded in the '71-'72 coding year and carried over into this year. See Graph 1.

Referring People and Facilities

A.P.S. accepts referrals from any source, but requires that the physician be involved in assessing the person's medical needs. A physician contacted A.P.S. To

GRAPH 1 TYPE OF SERVICE PROVIDED

N=2783



initiate a referral in 8% of the cases. Eight persons referred themselves, 347 relatives and 22 friends initiated referrals, which when combined constitutes 15% of the total. Six percent (6%) of the cases were referred from Public Health Nurses, Victorian Order Nurses, Visiting Homemakers, or other social service agencies. The largest proportion of cases (52%) were referred from non-physicians in acute care hospitals while 16% of the cases were initiated by non-physicians in extended care facilities. See Graph 2.

Graph 3 demonstrates the breakdown of referrals per month in the '72-'73 year. While there is a dramatic increase between September 1972 and August 1973 the rate of increase slowed down in 1973 with an average of 231 referrals per month (up to September). One would anticipate approximately 2800 referrals in the next year, if A.P.S. continues to operate at this rate.

The location of the applicant at the time of contact with A.P.S. (i.e. - when the referral was initiated) is as follows: 45% in acute treatment hospitals; 22% in extended care facilities (i.e. Psychiatric Hospital, Rehab Facility, Chronic Hospital, Nursing Home, or Home for the Aged); and 33% in the community (i.e. Lodging House, Special Living Facility, Support Services, Other and Home). See Graph 4

Placements

The "Final Placement"* recommendation was coded as the level of care that A.P.S. felt should be the "permanent" placement, unless the condition changed. For example, it may be recommended that an applicant be placed in a rehabilitation unit for approximately 6 weeks to improve ambulation and then (depending on the resulting improvement) be placed in a nursing home. The "final placement" recommendation would be the nursing home. (If the applicant is then placed in the nursing home, the date of placement is recorded.) The rehabilitation placement would be recorded as the first intermediate placement, if the applicant, was, in fact placed there. The intermediate placements (numbering one to four) may or may not have been recommended by A.P.S. There may also be subsequent placements where, for example, the applicant decided to leave the nursing home (final placement location) and go to live with some relatives.

Graph 5 indicates the location of the "final placement" recommendation, and Graph 6 indicates the location of the "final placement". The breakdown for institution and community recommendations/placements is the same in both graphs: 83% institutions, 17%

* definitions of terms can be found in Appendix A - Coding Definitions

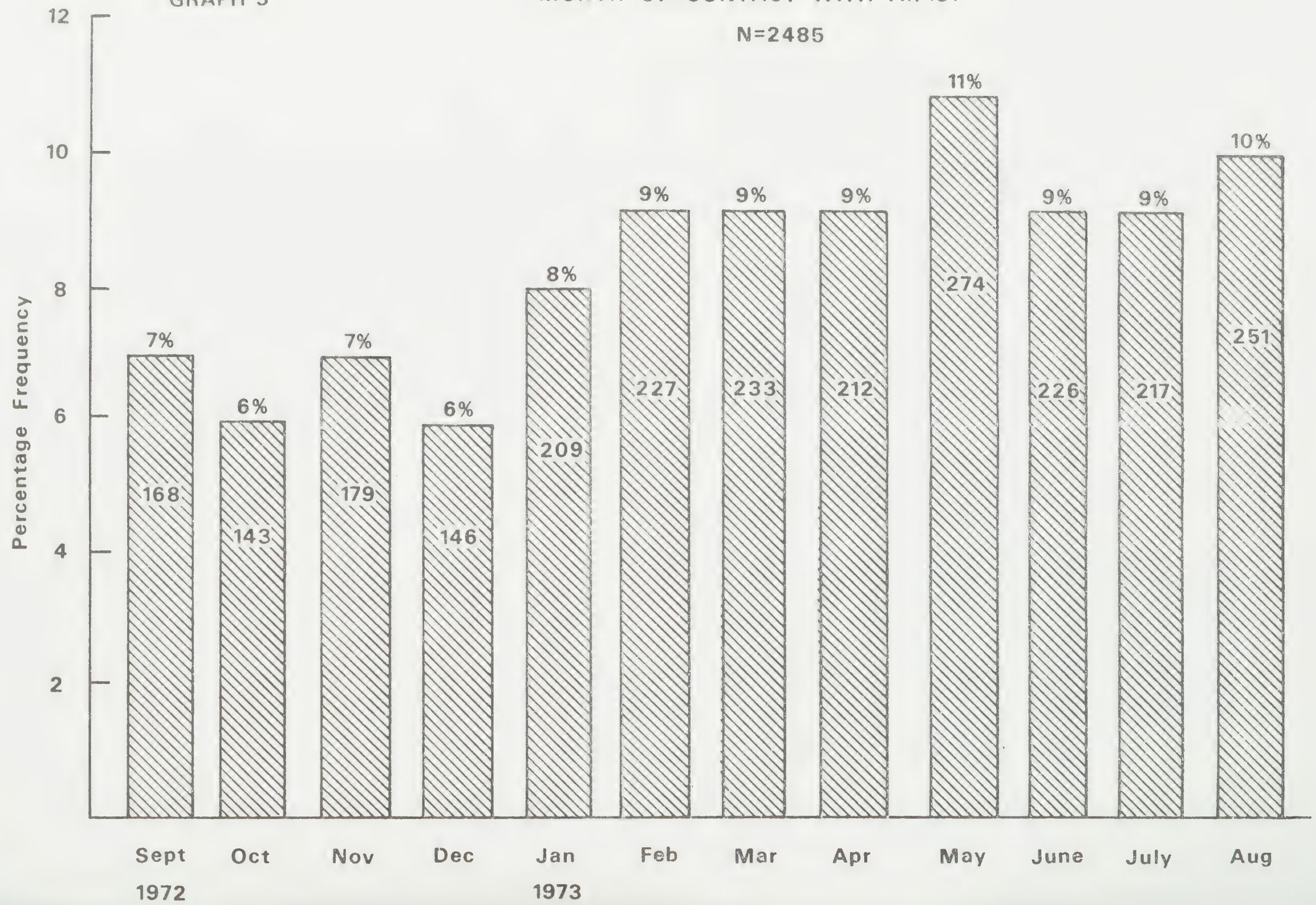
GRAPH 2

PERSON WHO FIRST MADE CONTACT WITH A.P.S.

GRAPH 3

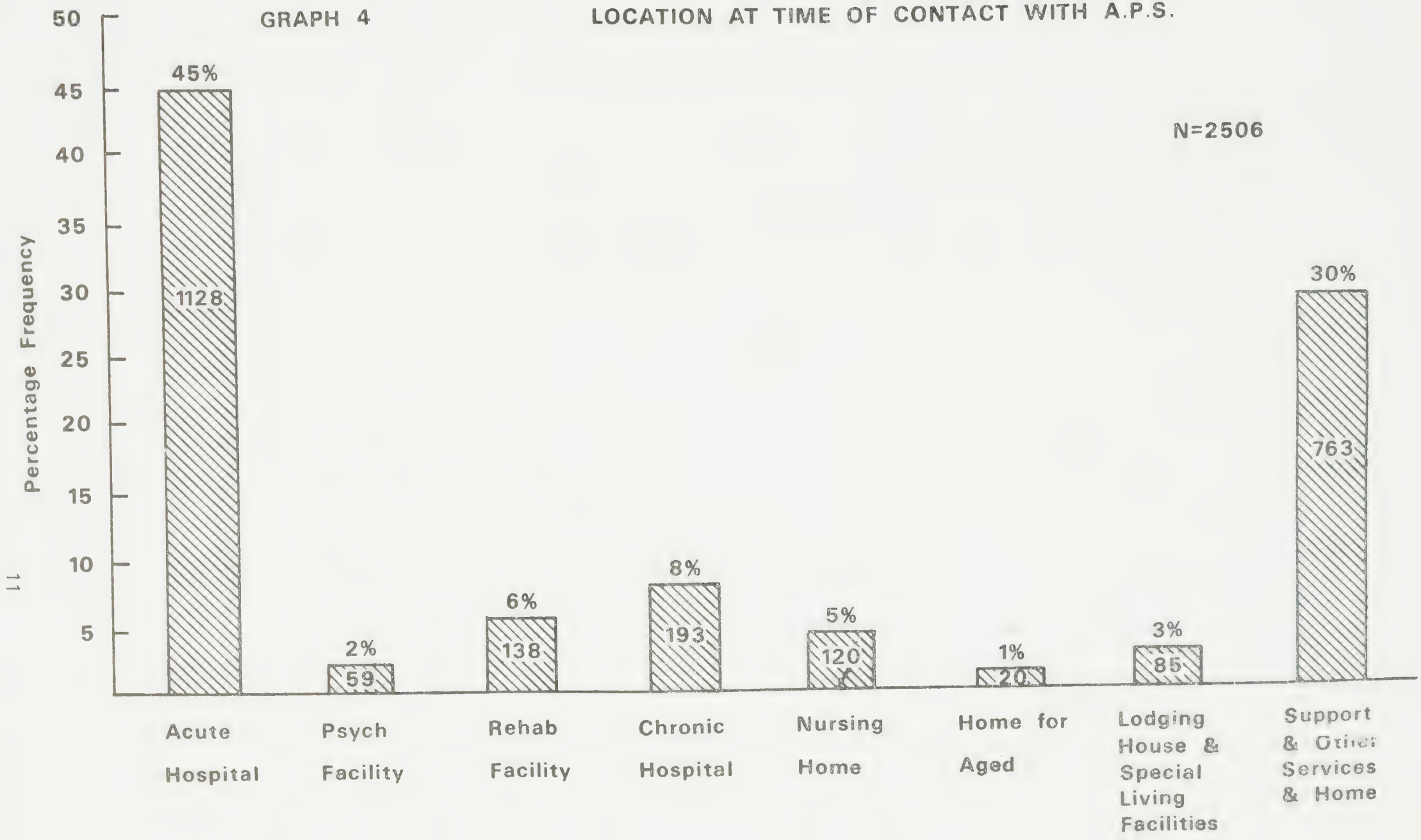
MONTH OF CONTACT WITH A.P.S.

N=2485

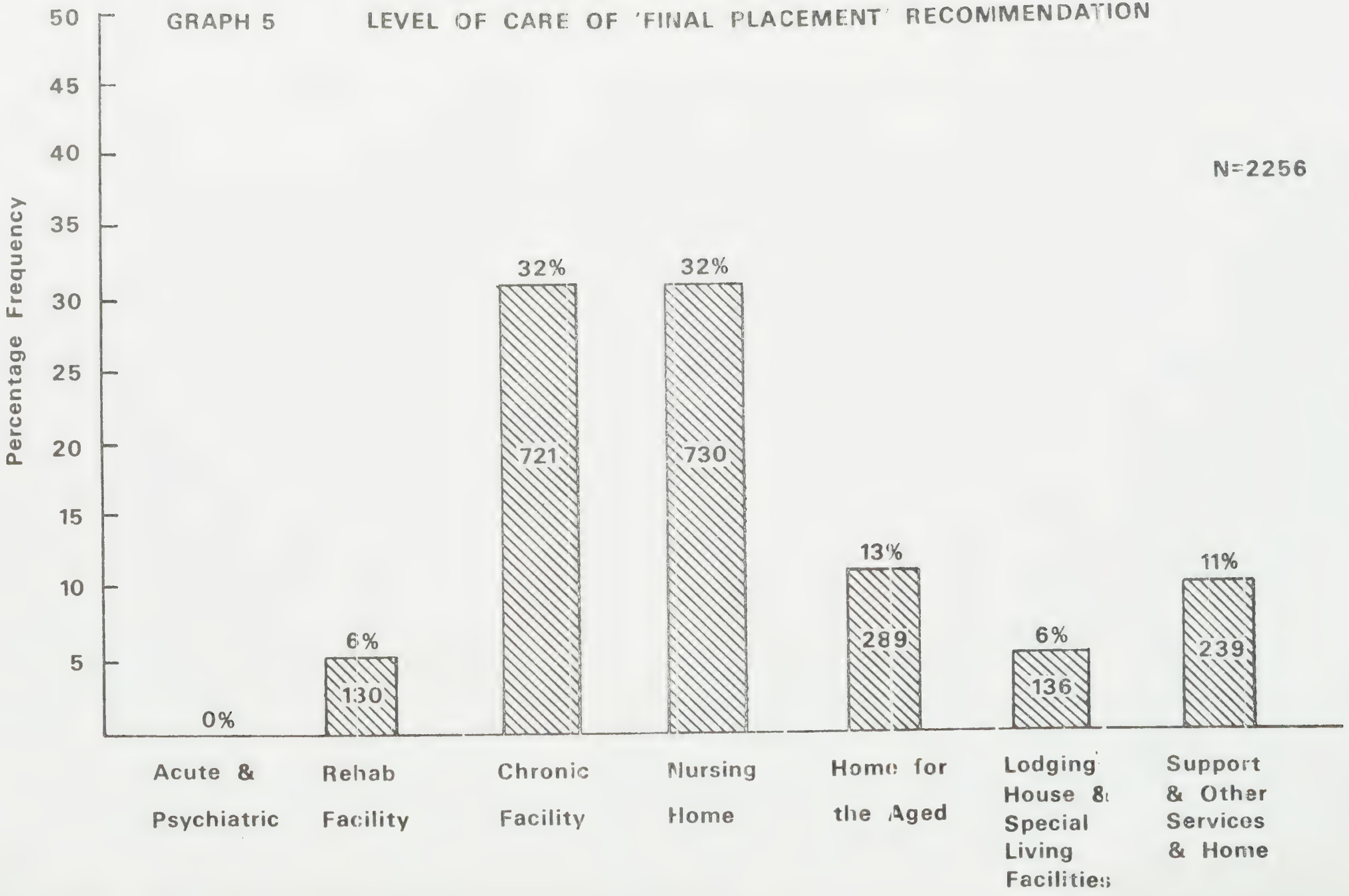


GRAPH 4

LOCATION AT TIME OF CONTACT WITH A.P.S.

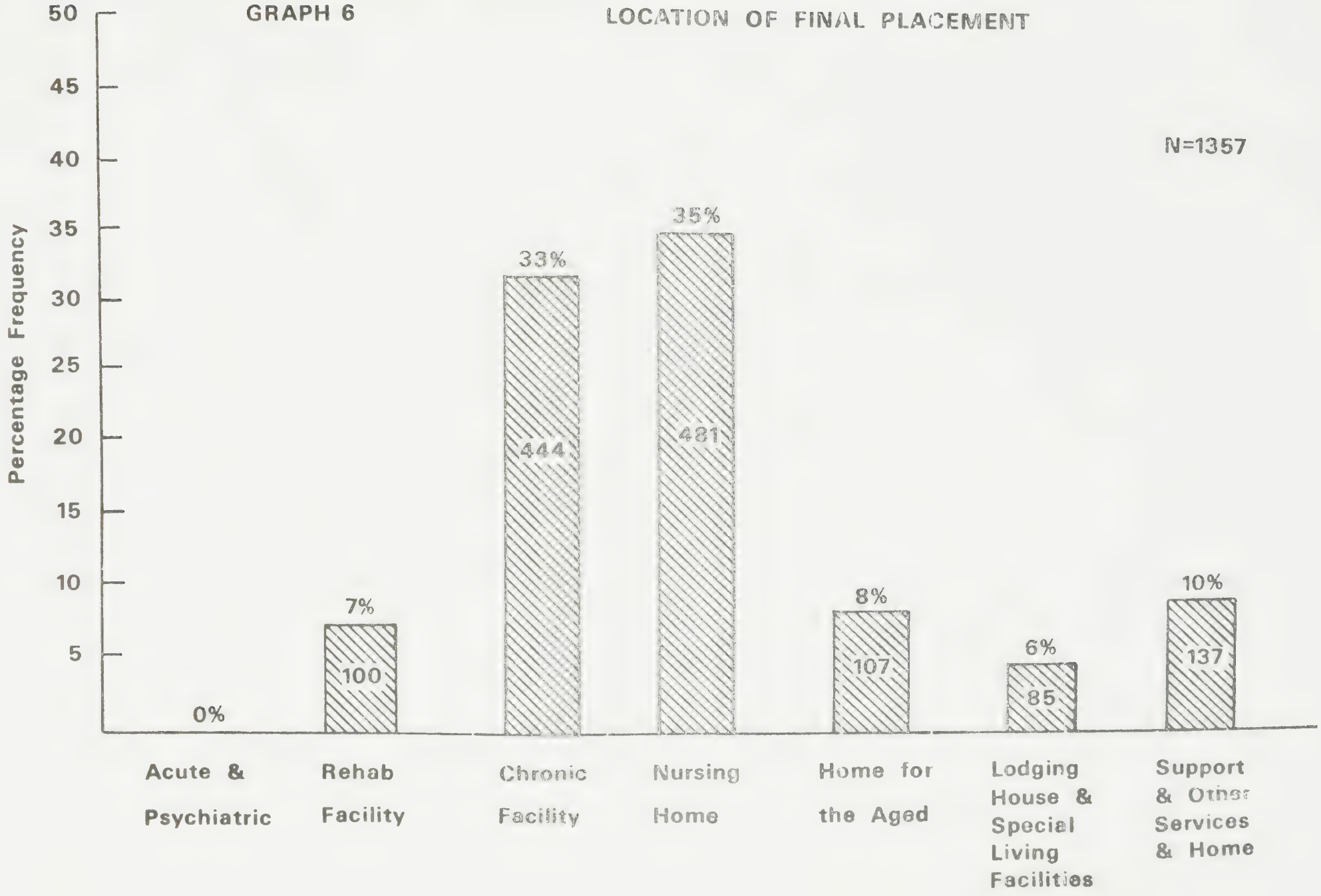


GRAPH 5 LEVEL OF CARE OF 'FINAL PLACEMENT' RECOMMENDATION



GRAPH 6

LOCATION OF FINAL PLACEMENT



community. Sixty-four percent (64%) of the recommendations and 68% of the placements were for chronic hospitals and nursing homes.

There were 2256 recommendations for final placement made but only 1357 final placements that were actually effected in the time period of this report. There were 899 applicants for whom recommendations had been made, but final placement had not been effected as of August 31, 1973. Further investigation into these cases revealed the following: 362 applicants had at least one intermediate placement; 110 applicants were re-referred and had no intermediate placement; 154 died before any placement; 23 died after an intermediate placement. According to the month-end statistics 264 people were waiting to be placed on August 31, 1973 (whether the placement is the final or intermediate is not indicated); and the assessment consultants were waiting for a response to their recommendations on 14 cases. Of the 340 of these (899) cases that were followed-up, 58% (or 197) were considered generally satisfactory but had refused the A.P.S. recommendation for placement.

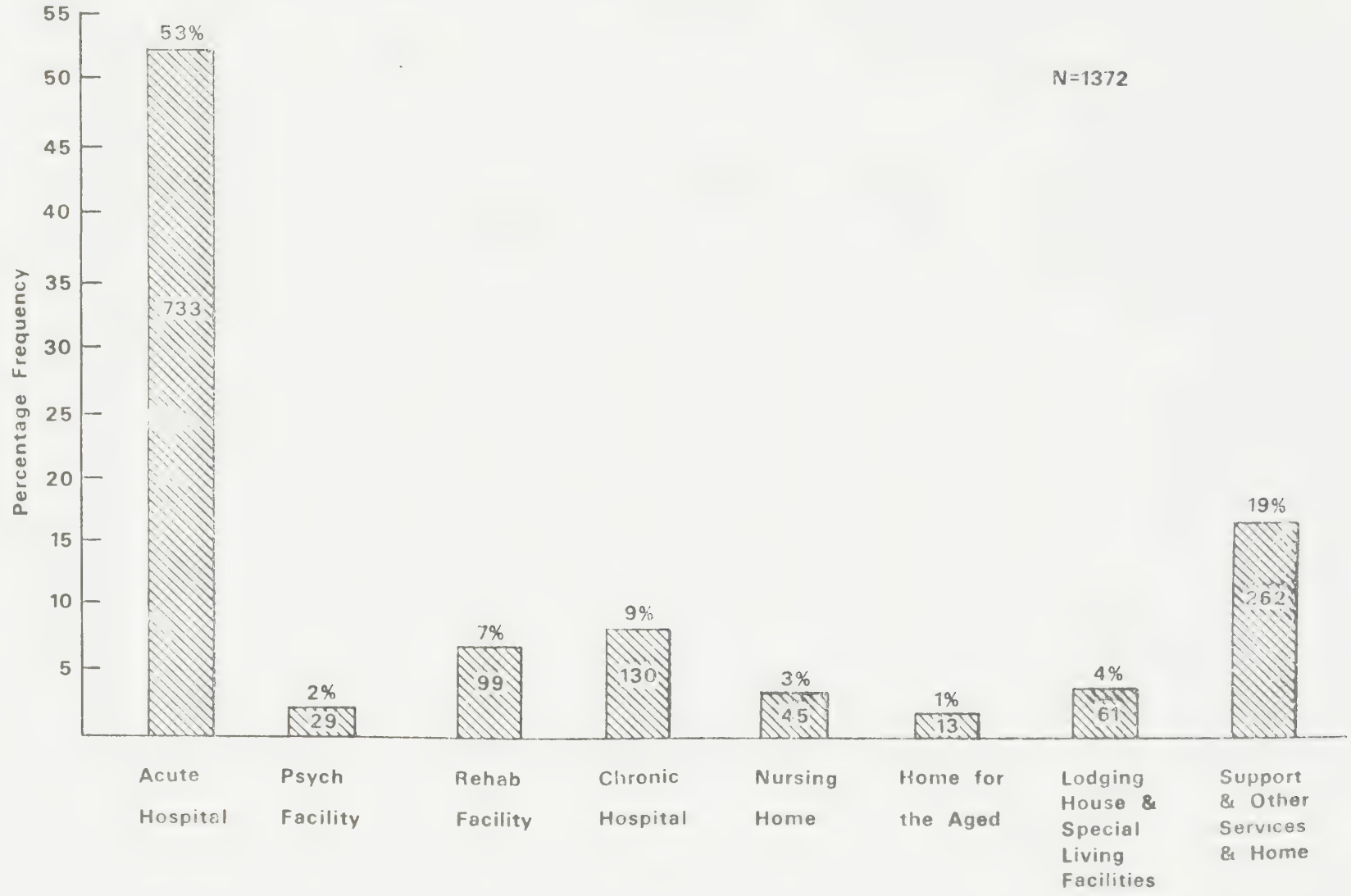
The location of the applicant just prior to his/her final placement was recorded. This could be taken to indicate where the person was located while his/her placement was being arranged. Graph 7 shows that 53% were located in acute treatment hospitals, and 19% were located at home with support, other or no services being provided. Graph 8 indicates the distribution of those located in acute treatment hospitals (that is the breakdown between the hospitals of the 53% who were located in that level of care). For comparative purposes, the relative size (i.e. - number of "rated" acute treatment beds) of each institution is as follows: Chedoke, 216; Hamilton General Hospital, 503; Henderson General Hospital, 715; Joseph Brant Hospital, 511; St. Joseph's Hospital, 648; McMaster University Medical Centre, 379.

The distribution of placements over the months between September 1972 and August 1973 is indicated in Graph 9. Graph 10 demonstrates the location of the first intermediate placements. Forty-one percent (41%) were placed at home with support, other, or no services being provided. A further 13% went into acute treatment hospitals, and notably, 18% into nursing homes. An intermediate placement may, in fact, be where the applicant will be permanently residing, if, for example the applicant refused to accept the A.P.S. recommendation for final placement.

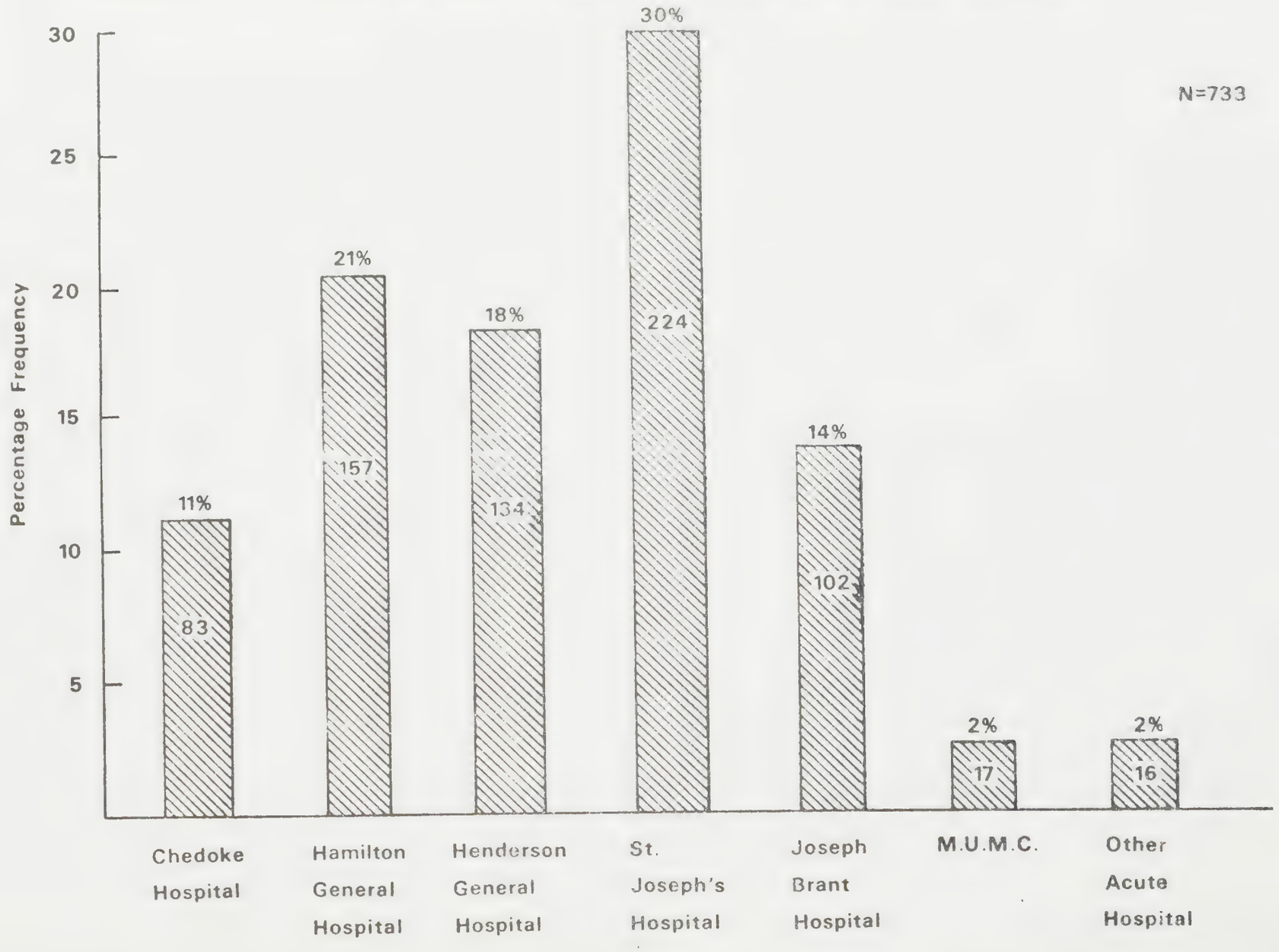
Graph 11 indicates the number, of first intermediate placements per month in the time period of this report. As with the number of final placements, the number of intermediate placements per month is not constant. Graph 12 demonstrates the location of the applicants just prior to their first intermediate

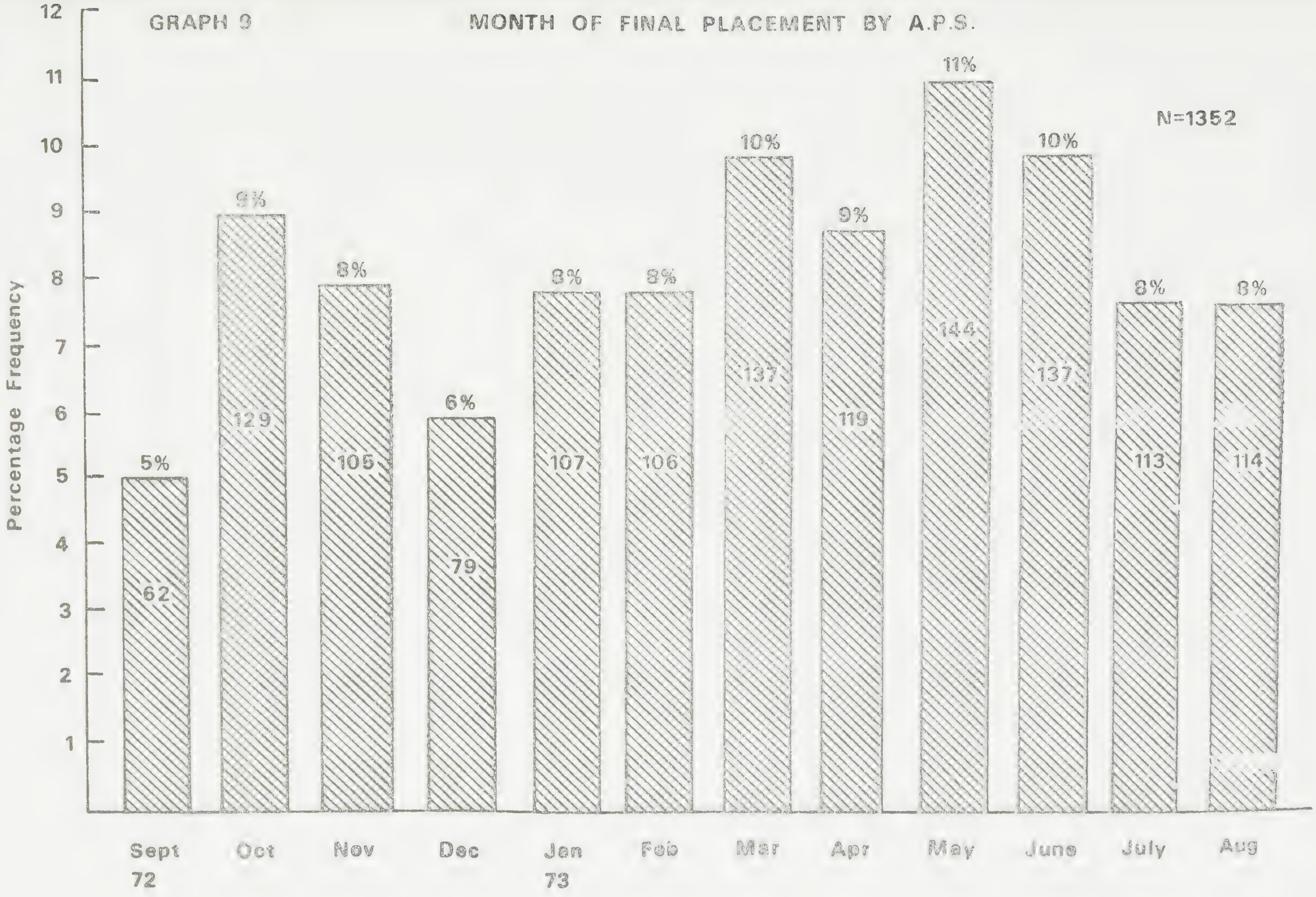
GRAPH 7

LOCATION PRIOR TO FINAL PLACEMENT



GRAPH 8 LOCATION PRIOR TO FINAL PLACEMENT (ACUTE CARE HOSPITAL)



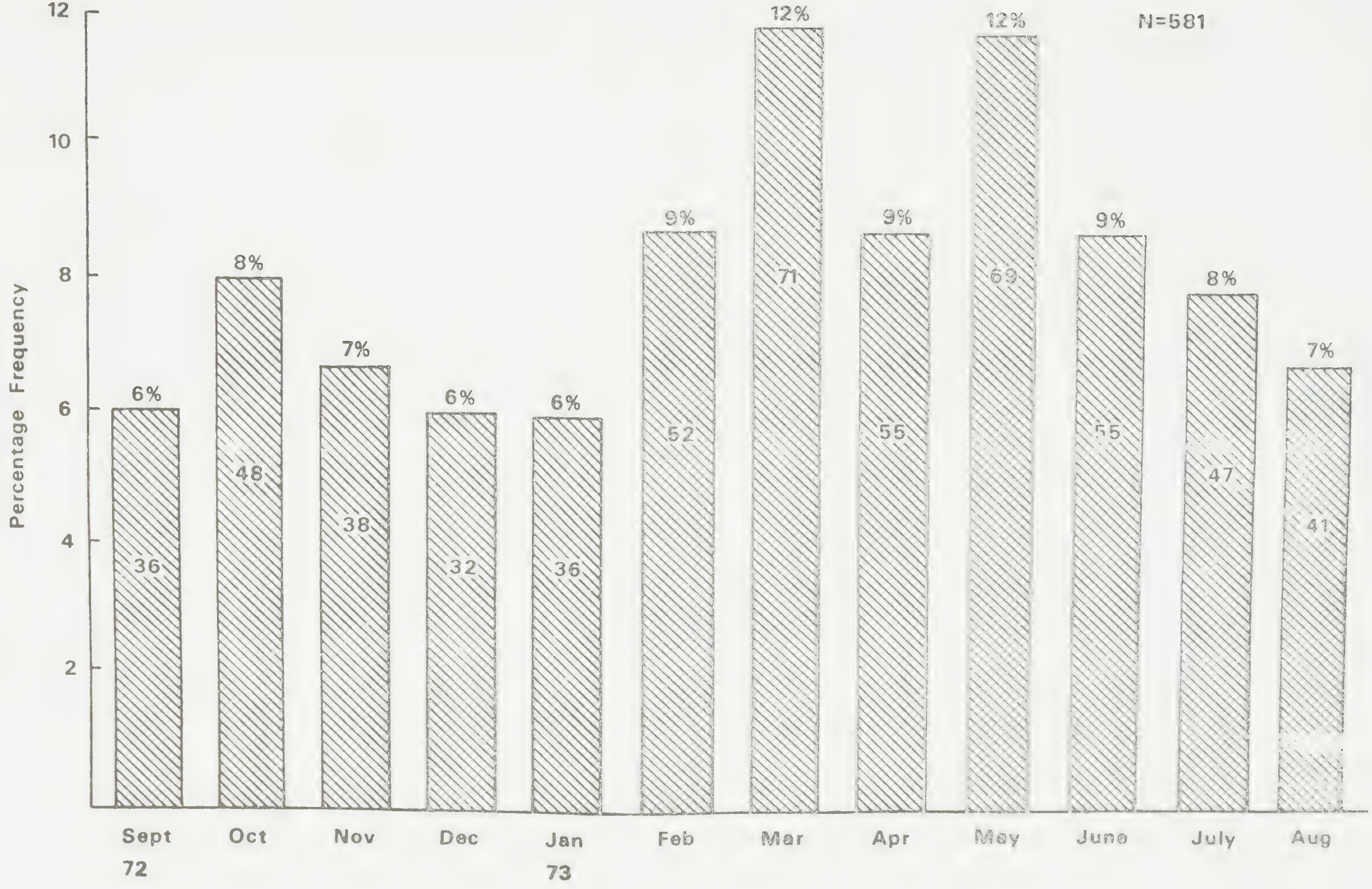

GRAPH 9
MONTH OF FINAL PLACEMENT BY A.P.S.
N=1352
Percentage Frequency
12
11
10
9
8
7
6
5
4
3
2
1
5%
62
9%
129
8%
105
6%
79
8%
107
8%
106
10%
137
9%
119
11%
144
10%
137
8%
113
8%
114
Sept
72
Oct
Nov
Dec
Jan
73
Feb
Mar
Apr
May
June
July
Aug

GRAPH 10

LOCATION OF FIRST INTERMEDIATE PLACEMENT

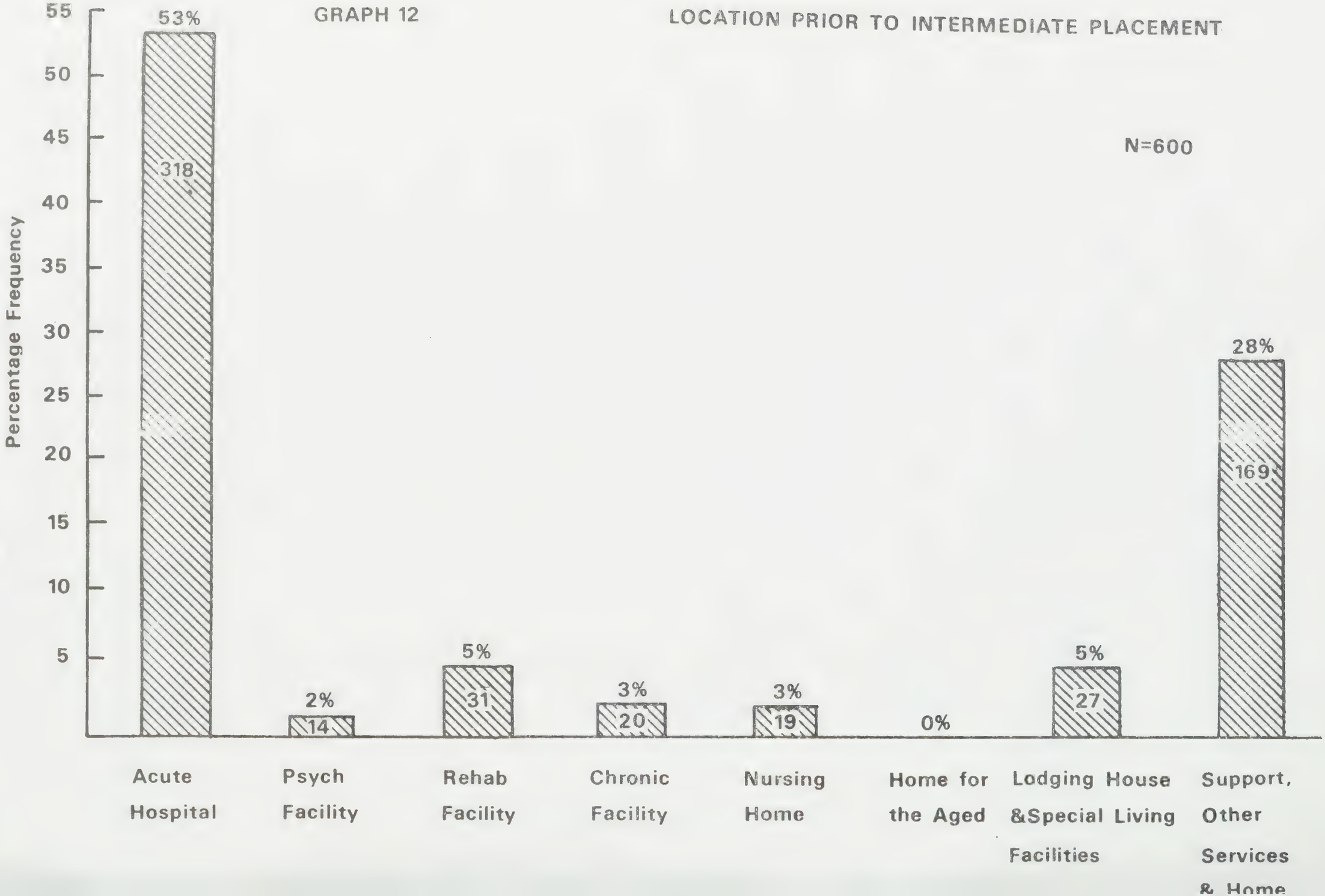
GRAPH 11

MONTH OF INTERMEDIATE PLACEMENT



GRAPH 12

LOCATION PRIOR TO INTERMEDIATE PLACEMENT



placement. Fifty-three percent (53%) of the applicants were located in acute treatment hospitals prior to their first intermediate placement. The same percentage were located in acute treatment facilities prior to final placement, as well. A further 28% were located at home with support, other or no services being provided. Table 1 demonstrates that 78% of the first intermediate placements were not recommended by A.P.S. A substantial number (202 our of 598) were sent home - possibly to await placement - without A.P.S. having been consulted, however. For each level of care except Rehabilitation Facility proportionately more of the first intermediate placements were not recommended by A.P.S. Sixty-three percent (63%) of the Rehab placements were, in fact, part of the initial plan for placement.

Upon occasion, there are several intermediate placements for any particular applicant. In the period of this report, 70 applicants had a second intermediate placement: 37% went home with support/other or no services being provided; 27% went to an acute treatment hospital; and 60 out of the 70 applicants (86%) had a placement that A.P.S. had not recommended. Only 13 people had a third intermediate placement and 3 had a fourth intermediate placement, to a sum total of 687 intermediate placements being recorded by A.P.S.

Some applicants are placed in the location that A.P.S. recommended for the final placement, but then have a subsequent placement, for one reason or another. The person may improve, deteriorate, make alternate arrangements, require hospitalization, etc. Graph 13 shows the location of the first subsequent placement: 47% went home with support, other or no services being provided (actually 41% had no services proviced); and 19% went to an acute treatment hospital. A.P.S. had not been involved in recommending the first subsequent placement in 78% of the 189 cases. There is record of 25 second subsequent placements: 20% home with support or no services being provided; and 36% went to a nursing home. Forty-four percent (44%) of the second subsequent placements were recommended (either as an initial or revised recommendation) by A.P.S. The following example of a subsequent placement might have been recommended initially: the applicant was placed in a nursing home (which was the location of the "final placement" recommendation) but then did not like that particular facility; his/her family then took the applicant home, with no formal services being provided, and contacted A.P.S. for the name of a different nursing home. The second nursing home placement would then be the second subsequent placement and it would have been recommended "initially" by A.P.S.

TABLE 1 APPLICANTS' FIRST INTERMEDIATE PLACEMENT BY WHETHER RECOMMENDED BY A.P.S. OR NOT*

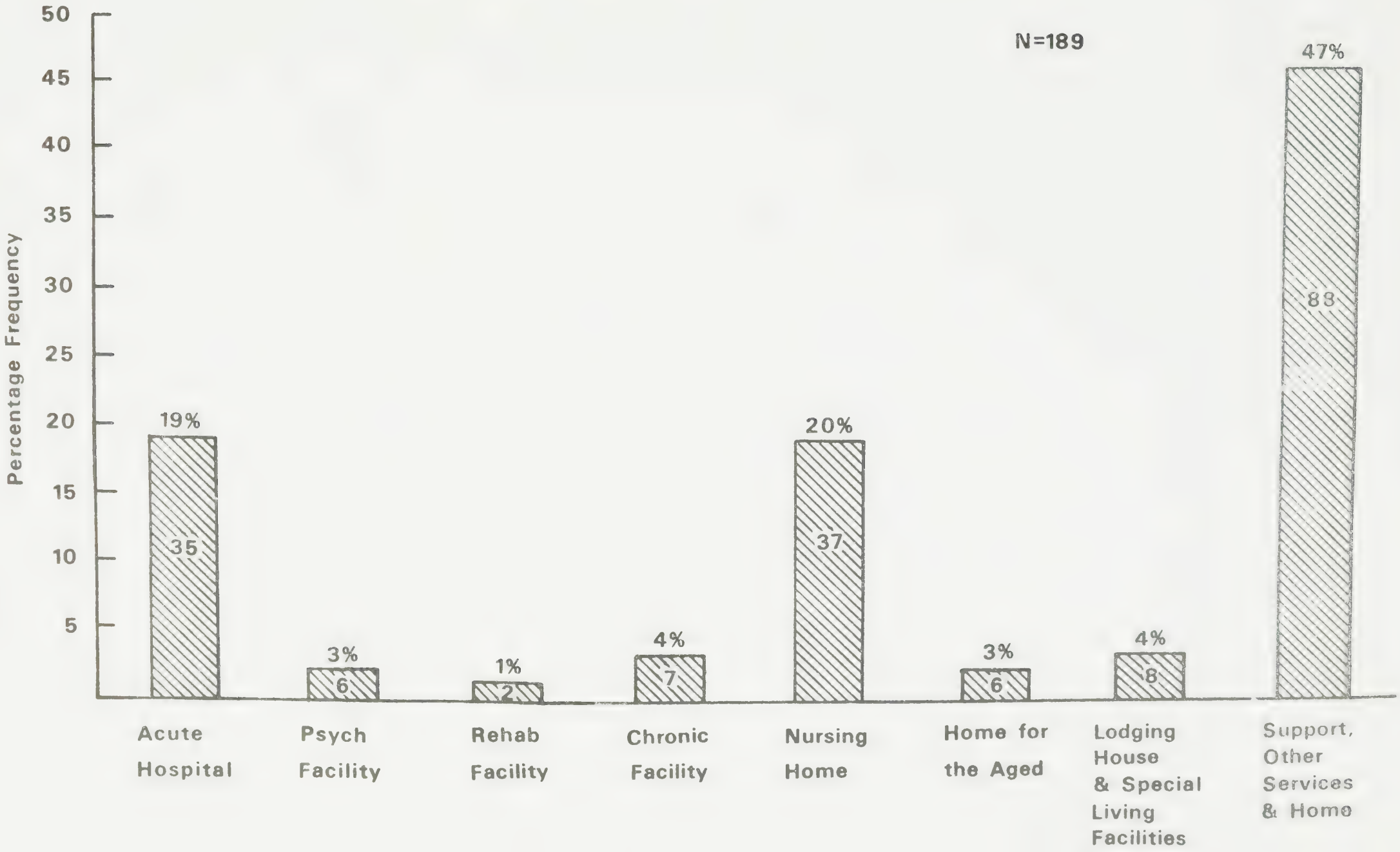
LOCATION OF FIRST INTERMEDIATE PLACEMENT	WHETHER RECOMMENDED PLACEMENT ACCEPTED			TOTAL
	Yes - initial plan	No	Yes - revised plan	
Acute Hospital	1 (1)	76 (99)	0 (0)	77 (100)
Psychiatric Facility	1 (6)	15 (88)	1 (6)	17 (100)
Rehab Facility	34 (63)	17 (31)	3 (6)	54 (100)
Chronic Hospital	8 (29)	19 (68)	1 (4)	28 (101)
Nursing Home	10 (9)	91 (83)	8 (7)	109 (99)
Home for the Aged	1 (7)	13 (87)	1 (7)	15 (101)
Lodging House & Other	10 (20)	34 (67)	7 (14)	51 (101)
Support Services & Home	29 (12)	202 (82)	16 (6)	247 (100)
TOTAL	94 (16)	467 (78)	37 (6)	598 (100)

N = 598 $P < .001$

*( ) indicates row percentage

GRAPH 13

LOCATION OF FIRST SUBSEQUENT PLACEMENT



It is quite certain that not all of the placements of A.P.S. applicants were recorded. There is a problem of being notified if a person has taken the suggestion to go to a lodging house, or special support program, for example, but most of the institutions do attempt to inform A.P.S. of any admissions or discharges. In addition, some people are still being placed in extended care programs without being involved with A.P.S. A.P.S. had record of: 1357 "final" placements, 687 intermediate placements and 215 subsequent placements, to a total of 2259 placements altogether. Some of these placements are home with or without support services.

The following is a breakdown of the number and percentage of institutional placements: final placements, 1135 or 83%; intermediate placements 354 or 52%; subsequent placements 110 or 51%; and overall total of placements, 1599 or 71% were institutional. These figures do give a good indication of the amount of movement (in terms of placement in facilities and programs) of people with chronic disability in this district in a year's time.

Table 2 compares the location of final placement with the location of the applicant at the time of contact (i.e. - when referred to A.P.S.) Of those placed in institutions a far greater proportion were already located in institutions at the time of contact. In addition, of those placed in the community, a slightly greater proportion were already located in community at the time of contact. However, regardless of the location at the time of contact, proportionately more people were placed in institutions rather than in the community.

Satisfaction with Placement

All cases are followed-up by telephone approximately one month after placement to determine if everything is satisfactory or not. It is recorded whether the placement is considered generally satisfactory or not, taking into account the facilities and programs as they presently exist, how the "placement" program meets the applicant's needs, as well as any problems encountered in the placement process. Table 3 gives the breakdown for the 11 categories for "satisfactory" and the 12 categories for "unsatisfactory". Of the 1005 cases that had been followed up as of August 31, 1973, 93% were considered generally satisfactory and only 8% were considered generally unsatisfactory. It will be noted that 4% (or 67 cases) were unsatisfactory because the applicant died within two weeks of placement.

TABLE 2 LOCATION AT TIME OF CONTACT WITH A.P.S. BY LOCATION OF FINAL PLACEMENT*+

LOCATION OF FINAL PLACEMENT	LOCATION AT TIME OF CONTACT		TOTAL
	Institution	Community	
Institution	841 (81) (89)	191 (19) (63)	1032 (100) (83)
Community	100 (47) (11)	113 (53) (37)	213 (100) (17)
TOTAL	941 (76) (100)	304 (24) (100)	1245 (100) (100)

N = 1245 $P < .001$

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

+ 'Institution' includes the following facilities and programs:
-Acute treatment hospital, psychiatric hospital, rehab facility, chronic hospital, nursing home, and Home for the Aged.

'Community' includes the following facilities and programs:
-Lodging houses, special living facilities, support and other services, home without services.

TABLE 3 SATISFACTION WITH PLACEMENT

PROBLEMS WITH PLACEMENT PROCESS	Generally Satisfactory N	%*	Generally Unsatisfactory N	%*
a-nothing listed as being (un)satisfactory.....	1046	58	0	0
b-a long wait was involved				
(i) due to lack of appropriate beds	39	2	0	0
(ii) due to other problems (eg family and/or patient didn't like suggested placement facilities)	72	4	0	0
c-family and/or patient didn't like actual placement facility	35	2	3	0
d-inappropriate placement				
(i) assessment incorrect	2	0	1	0
(ii) placed without A.P.S.	7	0	11	1
(iii) facility couldn't handle/didn't wish to keep patient	11	1	11	1
(iv) didn't work out very well for other or unknown reasons	10	1	10	1
e-patient placed before recommendations made	197	11	2	0
f-patient/family/referring facility refused recommendations	225	12	18	1
g-other	6	0	5	0
h-patient died within two weeks of placement	---	---	67	4
SUBTOTALS	1650	93	128	8
TOTAL	1778			

*percentage of total

These cases were followed-up even further, and it was determined that, in most cases, the early death was not expected at the time of transfer.

Table 4 shows the A.P.S. satisfaction with placements into the various levels of care. Proportionately more of the placements, regardless of the level of care, were considered generally satisfactory. But, 11% of the chronic hospital placements and 9% of the lodging house (and special living facilities) placements were considered unsatisfactory. Of the unsatisfactory placements, 53% had been placed in chronic hospitals and 29% in nursing homes. This is largely accounted for by the 47 people in chronic hospitals and the 15 people in nursing homes who died within two weeks of placement. Proportionately more institutional as opposed to community placements were considered generally unsatisfactory.

Graph 14 shows the stage in the process of assessing and placing applicants that some applicants died. Forty-three percent (43%) of the patients who died (i.e. - 216 people) did so prior to placement, and 57% (287 people) after placement. To some extent this indicates the severity of illness to the applicants to A.P.S., although caution must be exercised since the recording of the deaths after placement will in all likelihood not be as accurate and thorough.

Number of People Waiting for Placement

Once a recommendation has been made, and is accepted by the applicant, family, and treatment team, the applicant enters a queue to await the first appropriate vacancy. In the case of nursing homes, when a vacancy arises that might be appropriate for a number of people, generally the person who is in the most urgent need, or who has been waiting the longest will be asked to consider the vacancy. Both the nursing home and the applicant have the right to refuse that particular placement. In the case of chronic hospitals, and Homes for the Aged, the applicant enters a queue for a particular institution and is admitted in turn. People may wait for an appropriate vacancy anywhere in the range of a couple of hours to a couple of months. At the end of each month, the three A.P.S. consultants tally the number of people waiting for the different facilities on that particular day, to the best of their knowledge. There is some error here in that some people may have decided against placement and not notified A.P.S., or arranged a placement on their own, or they may have died in the meantime. Table 5 indicates, as accurately as is possible, the number of people waiting for the different levels of care and the status of the active

TABLE 4 SATISFACTION WITH PLACEMENT BY LOCATION OF FINAL PLACEMENT*

LOCATION OF FINAL PLACEMENT	SATISFACTION		TOTAL
	Satisfactory	Unsatisfactory	
Rehab Facility**	99 (98) (8)	2 (2) (2)	101 (100) (8)
Chronic Hospital	395 (89) (32)	48 (11) (53)	443 (100) (33)
Nursing Home	452 (95) (36)	26 (5) (29)	478 (100) (36)
Home for the Aged	99 (95) (8)	5 (5) (6)	104 (100) (8)
Lodging House & Other	74 (91) (6)	7 (9) (8)	81 (100) (6)
Support Services & Home	133 (98) (11)	3 (2) (3)	136 (100) (10)
TOTAL	1252 (93) (101)	91 (7) (101)	1343 (100) (101)

N=1343 $P < .05$

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

**Acute & Psychiatric Hospital(s) are included in this level of care grouping but the numbers are minimal

GRAPH 14

WHEN IN THE A.P.S. PROCESS THE PATIENT DIED

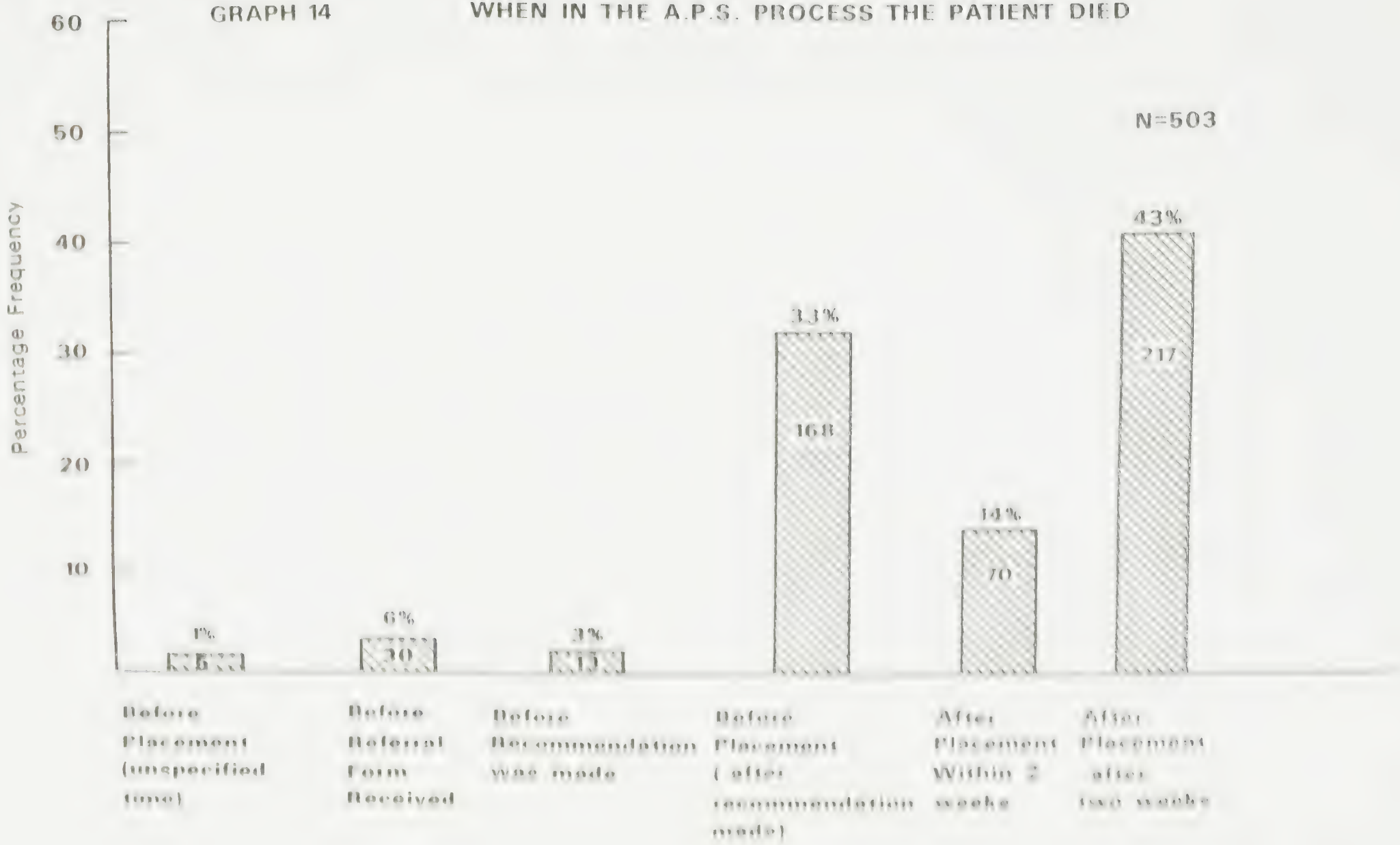


TABLE 5 STATUS OF ACTIVE CASES

DATE: August 31,1973 Summary for 3 A.P.S. Consultants

1. Placements (for the period August 1-31,1973) : 131

2. Waiting for Rehabilitation Unit — total: 14 males: 9 females: 5
3. Waiting for Chronic Hospital — total: 75 males: 27 females: 48
4. Waiting for Nursing Homes — total: 85 males: 39 females: 46
   -number requiring
   Extended Care: 66
   Intermediate: 3
   Undetermined: 16
   Accommodation :
   Ward: total: 79 males: 35 females: 44
   Semi: total: 5 males: 4 females: 1
   Priv: total: 1 males: 0 females: 1
5. Waiting for Homes for the Aged — total: 60 males: 21 females: 39
   -number requiring
   normal care: total: 39 males: 14 females: 25
   bed care: total: 4 males: 2 females: 2
   special care: total: 17 males: 5 females: 12
6. Waiting for Lodging Houses — total: 14 males: 10 females: 4
7. Waiting for Other Facilities — total: 16 males: 7 females: 9

8. Waiting for Assessment to be Returned: 56
9. Waiting for Response to Recommendations: 14
10. Waiting to be Conferenced: 3

TOTAL NUMBER WAITING FOR VACANCIES: total 264

TOTAL NUMBER OF ACTIVE CASES: total 337

cases on the day, August 31st, 1973. The number waiting for each month fluctuates with no particular trend becoming apparent at this time.

Number of Days in the Process of Assessing and Placing Applicants

One method of monitoring the extended health care systems is to record the number of days taken in the process of assessing and placing applicants to A.P.S. A measure of the efficiency of A.P.S. is the time between first contact (i.e. - the time of referral) and the receipt of a completed Referral Form, as well as the time between receipt of that form and the recommendation for placement being made. The time between the recommendation being made and placement (whether intermediate or final) gives some indication of the amount of backlog in the extended health care system. The mean time between contact and placement (intermediate or final) indicates how long, on the average, an applicant will have to wait for placement once a referral has been made to A.P.S.

There are several different approaches that could be used to calculate the number of days in the process. There were some negative values that were coded when, for example, a person was referred for statistics only and had already been placed when the referral form arrived at the office. In addition, if the cases that were carried over from last year are included in the calculation, there will be considerable overlap when comparing last year's data with the present data. The above two restrictions were used when calculating the number of days in the process in Table 6. A further restriction was imposed when looking at the figures for those who were actually placed in the location of final placement recommendation. These two approaches to the calculations can be compared in Table 6. The most striking difference is in the length of time between contact and receipt of the form: a 14% reduction in the length of time required, on the average, if the person was acutally placed in the final analysis. One possible explanation might be that the treatment team completing the form viewed these cases as more urgent and were faster in doing the assessment on these cases than on the less urgent ones.

As mentioned earlier, these calculations of the number of days in the process can be used to evaluate A.P.S. and the efficiency of the system. Using the figures for the general A.P.S. population (i.e. they were not necessarily placed) and comparing them to last year's calculations will indicate the improvement in a year. For the '71-'72 data, no negative

TABLE 6 NUMBER OF DAYS IN THE PROCESS OF ASSESSING AND PLACING APPLICANTS TO A.P.S.

STAGES IN THE PROCESS	CALCULATIONS							
	NO NEGATIVE VALUE & REFERRED IN THE '72-'73 CODING YEAR				NO NEGATIVE VALUES,REFERRED IN'72-'73 CODING YEAR & ACTUALLY PLACED (IN LOCATION OF FINAL PLACEMENT RECOMMENDATION)			
TIME BETWEEN	HIGH	LOW	KNOWN CASES	MEAN	HIGH	LOW	KNOWN CASES	MEAN
Contact-Receipt of Form	159	0	2138	4.58	72	0	1220	3.96
Receipt of Form-Recommendation	18	0	2100	.77	18	0	1222	.76
Recommendation-First Intermediate Placement	240	0	333	19.76	86	0	54	18.17
Recommendation-Final Placement	309	0	1057	23.11	309	0	1057	23.11
First Intermediate Placement-Final Placement	204	0	85	36.18	204	0	85	36.18
Contact-First Intermediate Placement	240	0	410	21.81	93	1	66	19.97
Contact-Final Placement	309	0	1075	27.94	309	0	1075	27.94

values were coded and it was the first full year of operation. The time last year between contact and receipt of the form ranged from 0 to 142 days with a mean value of 7.93 days; as compared to a 0 to 159 day range this year and a mean value of 4.58 days. In other words, the speed with which the completed forms are sent to A.P.S. has dramatically improved. The efficiency of the A.P.S. staff is measured by the length of time needed to conference a case and make recommendations: last year, the time ranged from 0 to 132 days with a mean value of 1.32 days; while this year the range was from 0 to 18 days with a mean value of .77 days. There has been an increase in the time taken to locate an appropriate vacancy and effect placement though: last year, the time ranged from 0 to 185 days with a mean of 15.08 days; while this year the time ranged from 0 to 240 or 309 days (whether you wish to calculate to the date of intermediate or final placement respectively) with a mean value of 19.76 or 23.11 days. The average length of time a person could expect to wait (from time of contact to placement) is now in the range of 21.81 to 27.94 days. The level of care which requires the longest waiting time is Homes for the Aged where 52% wait 50 days or more and 29% wait 75 days or more.

Utilization of A.P.S.

Each acute treatment hospital in the district calculated the number of discharges they made into "extended care facilities" by the month from September 1972 to August 1973. There is a problem in this time period of uniform definition, coding and retrieval of the information. All district hospitals will be using identical definitions, coding techniques and retrieval methods after January 1974, when they all will be using the HMRI (medical records) system. An example of the problem is as follows: last year St. Joseph's Hospital claimed to discharge only 90 people to extended care facilities between December 1971 (when they began using A.P.S.) and August 1972, while A.P.S. claimed to be involved in 110 such cases. The preliminary statistics for 1972-1973 were similar: St. Joseph's Hospital claimed 146 discharges, while A.P.S. placed 232. Obviously this is a problem of definition. St. Joseph's Hospital only included nursing homes and Homes for the Aged in their coding category of "extended care" facility. As a result additional data on the discharges to "other hospitals" (psychiatric, rehab, chronic as well as other acute) was requested. This may now be an over-representation, since it can not be determined how many acute hospital transfers are included here.

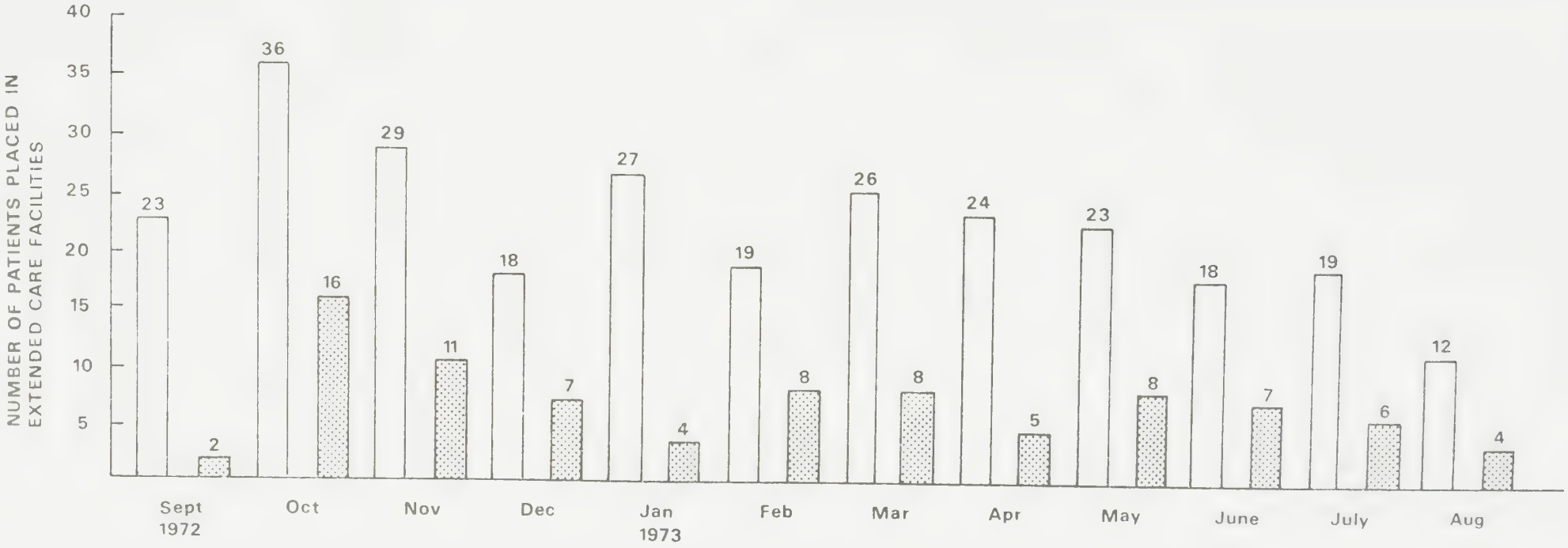
Graphs 15 to 19 compare the number of discharges into extended care facilities as reported by the five acute treatment hospitals and A.P.S. respectively. There is not a graph to represent the Joseph Brant Memorial Hospital in Burlington, since they were unable to provide discharge data from the hospital as a whole. Some data was obtained on discharges from the rehab and chronic wards but these account for only 34 out of the 142 extended care discharges that A.P.S. has record of.

Graph 20 compares the figures for the Hamilton Psychiatric Hospital (discharges from both acute and long term wards). The utilization rate for each facility is listed on their respective graphs. While all discharges to extended care facilities are supposed to go through A.P.S., obviously they are not. While some of the discrepancy is due to a definitional problem, an undetermined amount of the discrepancy may also be due to the admission and readmission to hospital of patients from extended care facilities for a short period of time, while their bed is reserved in the long term facility, awaiting the person's return. A.P.S. would not be involved here. An undetermined amount may also be due to the acute care facilities circumventing the system and placing people without going through A.P.S.

The utilization rates for the "receiving" institutions is more encouraging. Graphs 21 to 23 represent the number of admissions by the month to chronic hospital, nursing homes and Homes for the Aged, respectively, compared to the number in which A.P.S. has record of involvement. The facilities were asked not to include readmissions. Since most people would not be discharged directly from an acute treatment facility to a Home for the Aged, the figure of particular interest is that of the total admissions to nursing homes, compared to the A.P.S. figure. A 58% utilization rate, excluding readmissions (from hospital or elsewhere) suggests that some acute treatment hospitals are admitting people to nursing homes, in particular, without going through A.P.S. Some of the nursing homes, in turn, are undoubtedly accepting a substantial number of people without first having them assessed by A.P.S.

In '72-'73 A.P.S. was in its second year of operation and still growing. Table 7 compares the utilization rates by the district facilities for our first two years of operation. A.P.S. grew in acceptance over those two years and improved its utilization rate in each acute treatment facility, and in the chronic hospitals, nursing homes and Homes for the Aged in the district.

GRAPH 15 Chedoke Hospital: Number of Discharges to Extended Care Facilities by Chedoke Hospital compared to the Number of Placements into Extended Care Facilities made by A.P.S., in the same month, of Patients that were located in Chedoke Hospital just prior to placement:



Definition of
'Extended Care Facility':
a) for Chedoke Hospital: Mental Hospitals (long term wards), Convalescent Hospitals (Rehab Units), Chronic Hospitals, Nursing Homes, Homes for the Aged, Rest Homes
b) for A.P.S. : Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged

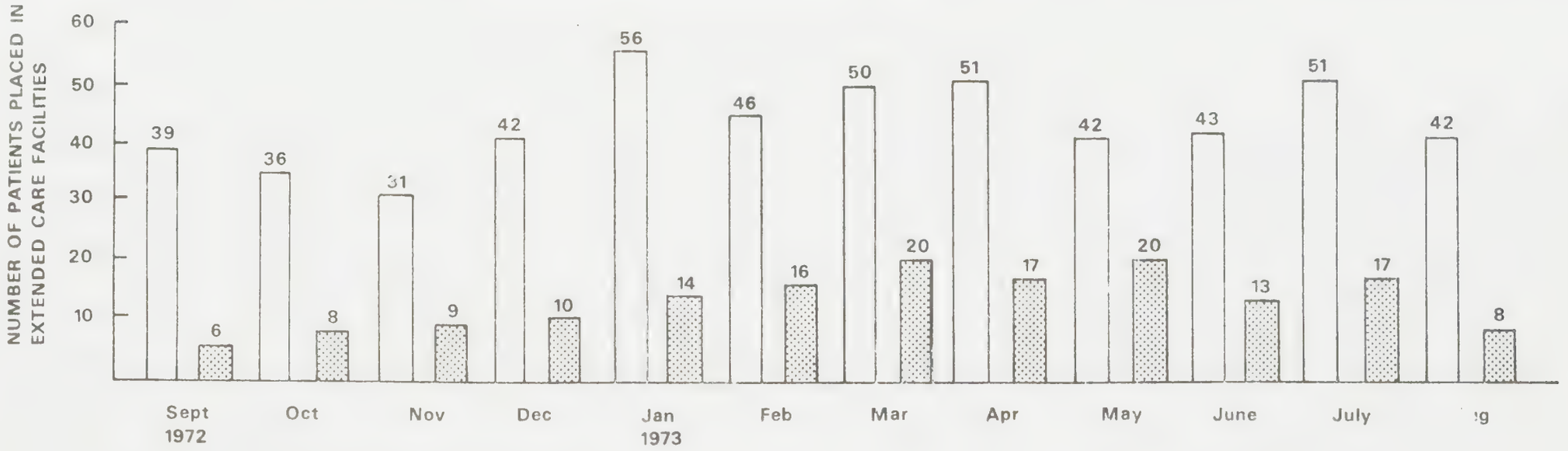
LEGEND

Hospital Discharges ..Total Sept 1972-Aug 1973 = 275

A.P.S. Placements...Total Sept 1972-Aug 1973 = 86

Utilization = 31%

GRAPH 16 Hamilton General Hospital: Number of Discharges to Extended Care Facilities by Hamilton General Hospital compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the same month, of Patients that were located in the Hamilton General Hospital just prior to placement



LEGEND

Hospital Discharges...Total Sept 1972-Aug 1973 = 529

A.P.S. Placements...Total Sept 1972-Aug 1973 = 158

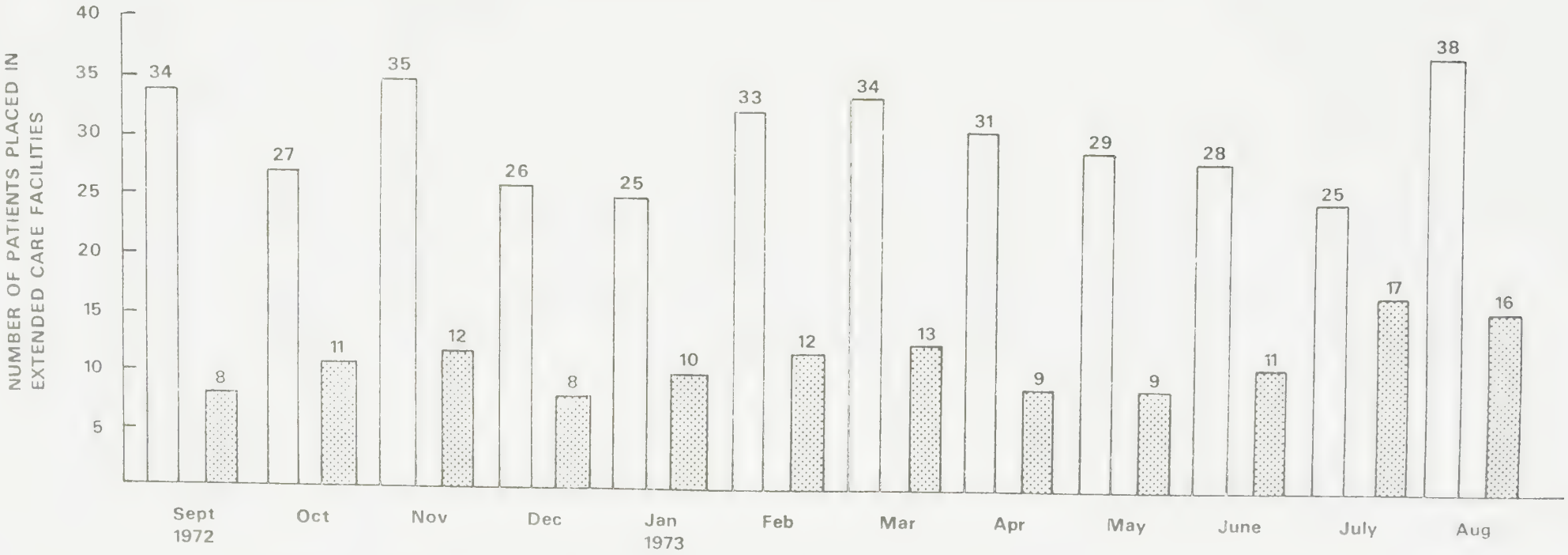
Utilization = 30%

Definition of 'Extended Care Facility':

(a) for Hamilton General Hospital: Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged (excludes Mental Hospitals). Included 'Other Hospital' in their coding definition so it might include some acute hospital discharges and therefore be an over-estimation.

(b) for A.P.S. Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.

GRAPH 17 Henderson General Hospital: Number of Discharges to Extended Care Facilities by Henderson General Hospital compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the same month of Patients that were located in Henderson Hospital just prior to placement.



LEGEND

Hospital Discharges Total Sept 1972-Aug 1973 = 365

A.P.S. Placements...Total Sept 1972-Aug 1973 = 136

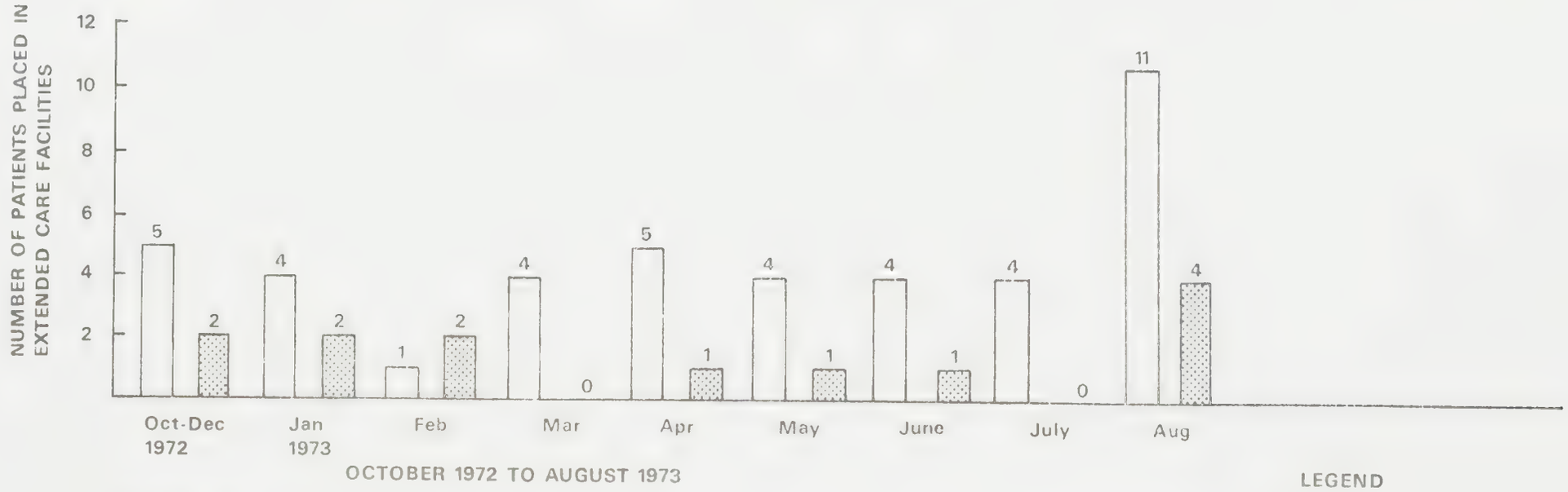
Utilization = 37%

Definition of 'Extended Care Facility'

(a) for Henderson General Hospital: Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged (excludes Mental Hospitals)

(b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.

GRAPH 18 McMaster University Medical Centre: Number of Discharges to Extended Care Facilities by M.U.M.C. compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the same month, of patients that were located in M.U.M.C. just prior to placement.



Definition of
'Extended Care Facility':
(a) for McMaster University Medical Centre: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.
(b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.

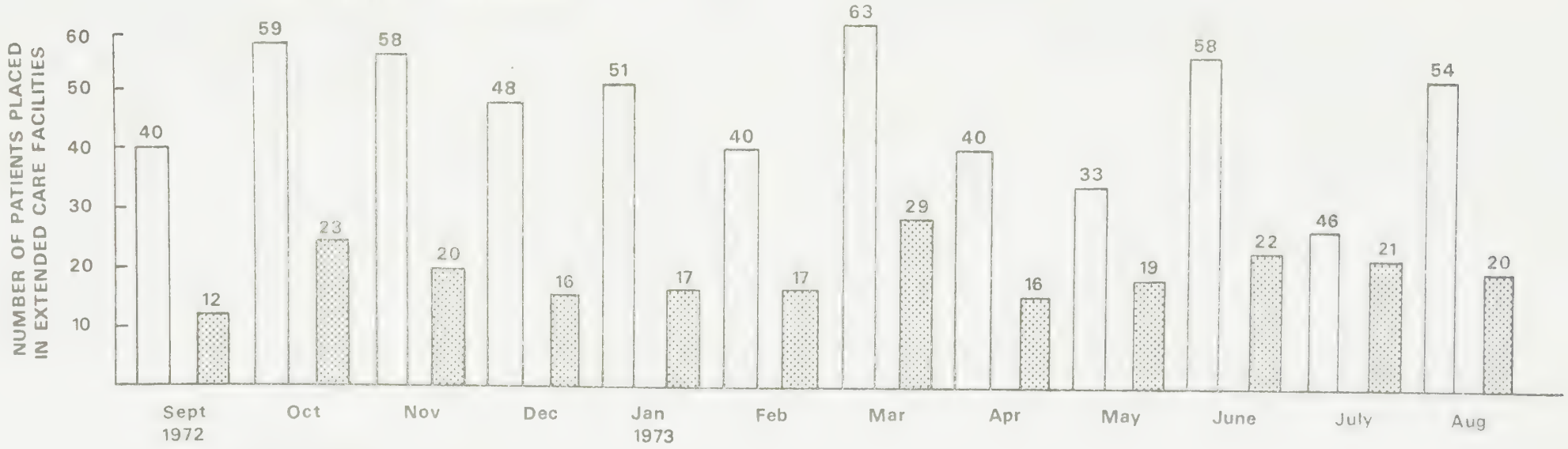
LEGEND

Hospital Discharges...Total Oct 1972-Aug 1973 = 42

A.P.S. Placements...Total Oct 1972-Aug 1973 = 13

Utilization = 31%

GRAPH 19 St. Joseph's Hospital: Number of Discharges to Extended Care Facilities by St. Joseph's Hospital compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the same month of Patients that were located in St. Joseph's Hospital just prior to placement.



SEPTEMBER 1972 TO AUGUST 1973

LEGEND

Hospital Discharges...Total Sept 1972-Aug 1973 = 590

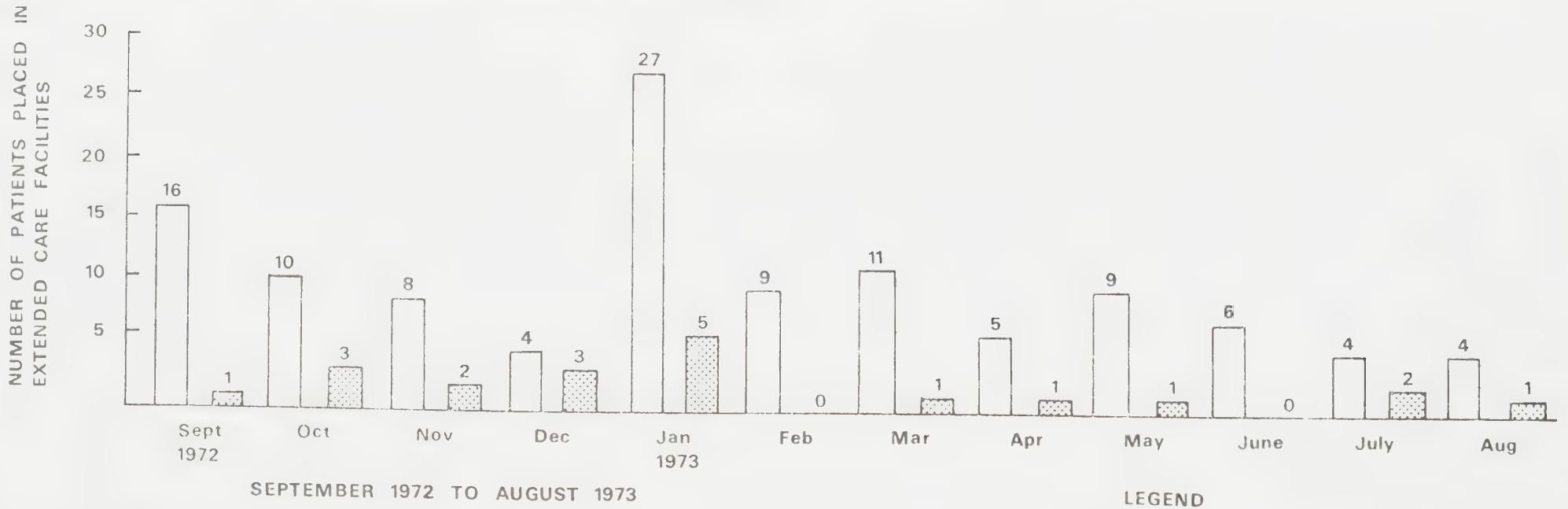
A.P.S. Placements. Total Sept 1972-Aug 1973 = 232

Utilization = 39%

Definition of 'Extended Care Facility':
(a) for St. Joseph's Hospital: Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.
(b) for A.P.S.: Rehabilition Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.

N B – The Hospital figures include 'Other Hospital' in their coding definition. The Medical Records Dept. felt that approximately 10% of the 'Other Hospital' discharges (590) were to other acute treatment facilities

GRAPH 20 Hamilton Psychiatric Hospital: Number of Discharges to Extended Care Facilities by Hamilton Psychiatric Hospital compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the same month of Patients that were located in the Hamilton Psychiatric Hospital just prior to placement



Definition of
'Extened Care Facility':
(a) for Hamilton Psychiatric Hospital: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.
(b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged.

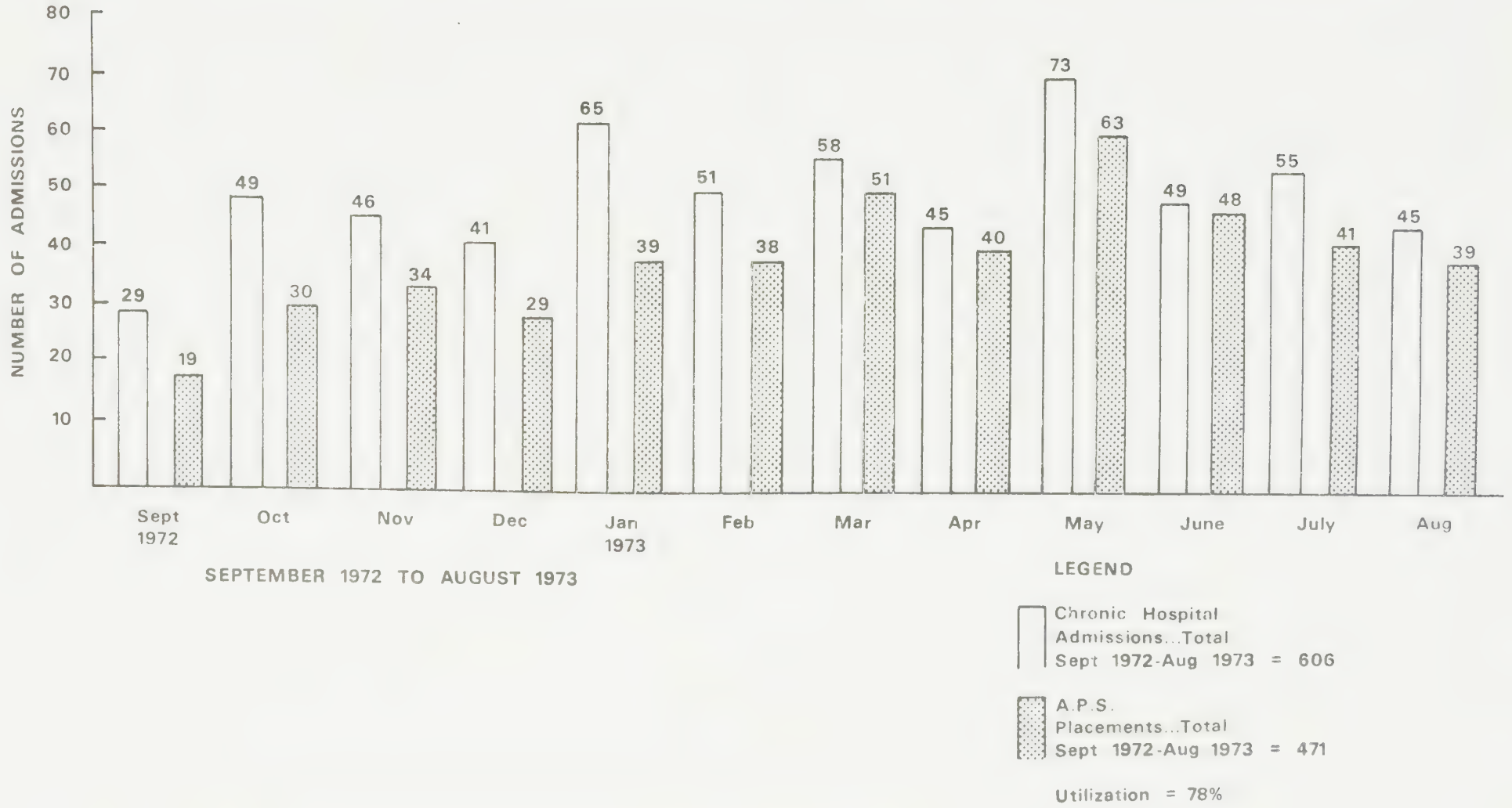
LEGEND

Hospital Discharges...Total Sept 1972-Aug 1973 = 113

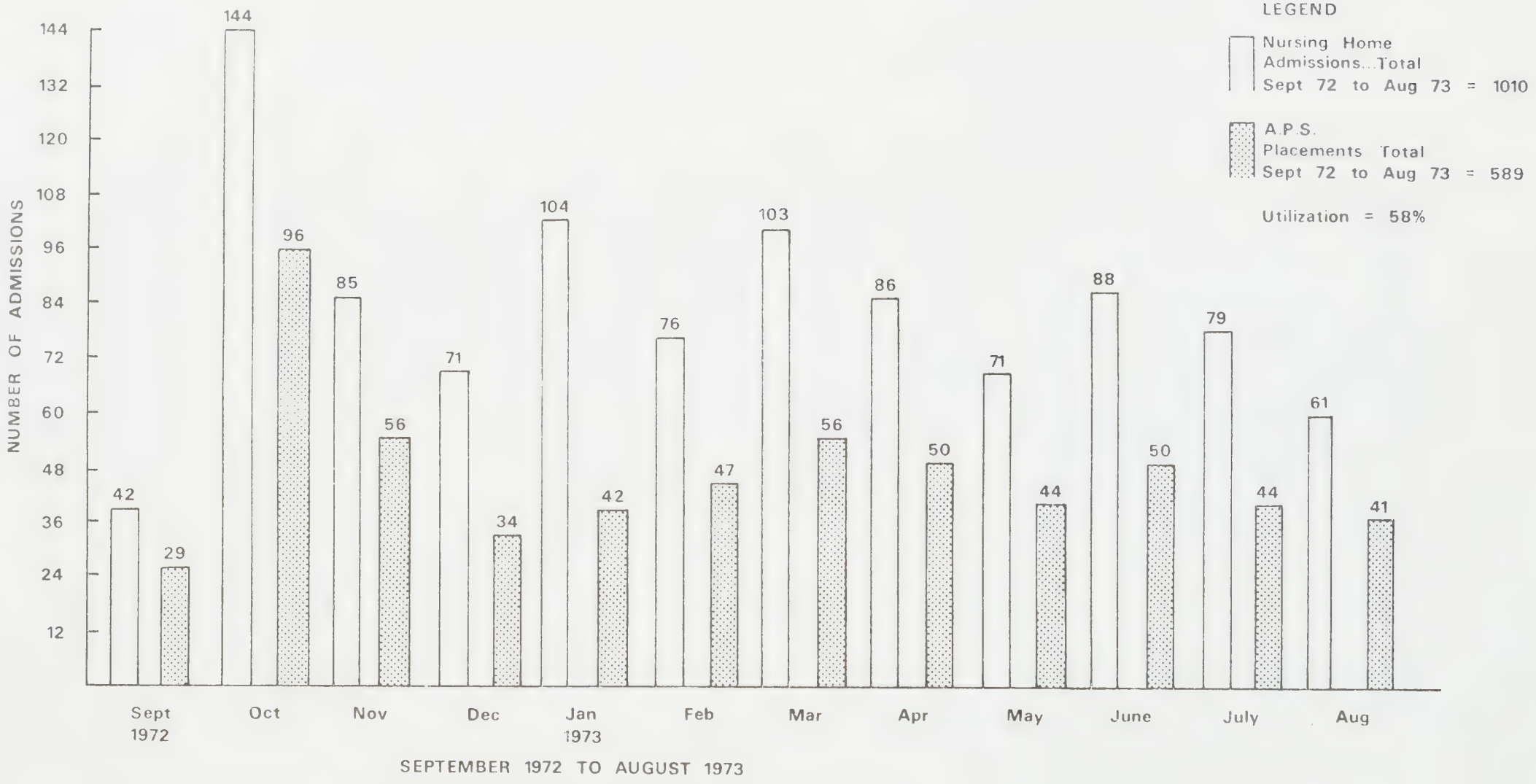
A.P.S. Placements...Total Sept 1972-Aug 1973 = 20

Utilization = 18%

GRAPH 21 Chronic Hospitals: Number of Admissions to All Chronic Hospitals in the District Compared to the Number of Placements into Chronic Hospitals made by A.P.S. in the same month.



GRAPH 22 Nursing Homes: Number of Admissions to all Nursing Homes in the District compared to the Number of Placements into Nursing Homes made by A.P.S. in the same month.*



*data not available from one nursing home for the months of September to December 1972

GRAPH 23 Homes for the Aged: Number of Admissions to all Homes for the Aged in the District compared to the Number of Placements into Homes for the Aged by A.P.S. in the same month.

TABLE 7 A.P.S. UTILIZATION RATES BY DISTRICT HEALTH CARE FACILITIES-COMPARING TWO YEARS OF OPERATION

FACILITY	'71-'72 Rate	'72-'73 Rate
Chedoke Hospital	30%	31%
Hamilton General Hospital	25%	30%
Henderson General Hosp.	21%	37%
M.U.M.C.	---	31%
St. Joseph's Hospital	122%	159% (39)*
H.P.H.	---	18%
Chronic Hospitals	38%	78%
Nursing Homes	38%	58%
Homes for the Aged	22%	46%

*revised rate, when recalculated to include other hospitals: psychiatric, chronic, & rehab and not just nursing homes and Homes for the Aged.

PART III: DESCRIPTION OF THE POPULATION SERVED BY A.P.S.

The following section describes the characteristics of the population that A.P.S. served in the '72-'73 year. In comparison with the A.P.S. First Annual Report - '71-'72 it will be noted that although the number of people served increased dramatically, the characteristics of the population remained almost exactly the same, for the most part. Although we cannot say that we have identified the total population needing extended care during this time period, in Hamilton district, we have served an almost identical subgroup for two consecutive years of operation.

District Served

A.P.S. was set up to serve the area under the jurisdiction of the Hamilton District Health Council. Included in this definition of the district are: Hamilton, Ancaster, Beamsville, Binbrook, Burlington, Dundas, Caledonia, Freelton, Grimsby, Lynden, Mount Hope, Stoney Creek, Vineland, Waterdown, West Lincoln, Winona. Ninety-four percent (94%) of our applicants were from within this district. The 5% from outside the district may have consisted of people whose relatives lived in this area and therefore wished to be placed here; or of people who were only assessed for a level of care recommendation, and were then placed in their own communities.

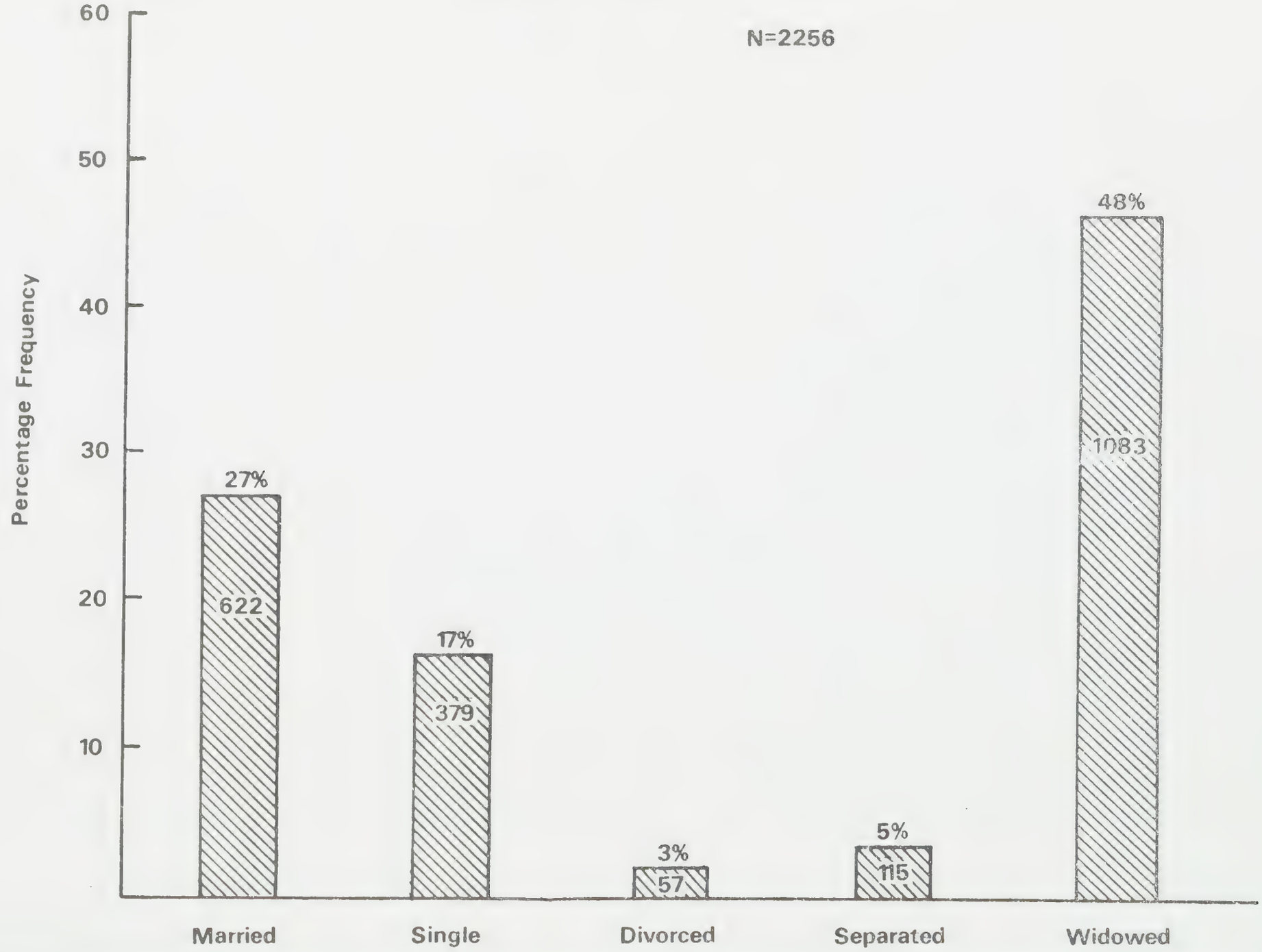
Demographic Data: Age, Sex, Marital Status, Etc.

The following section describes the basic demographic characteristics of the A.P.S. population. The applicants to A.P.S. were primarily women: 59% female, 41% male. Forty-eight percent (48%) of the applicants were widowed, while only 27% were still married. See Graph 24. Applicants to A.P.S. ranged in age from 4 to 102 years of age. Seventy percent (70%) of the people were 70 years of age or older. See Graph 25.

In Table 8, it can be seen that proportionately more men are either married, divorced, separated or classified as "Other" or "Don't Know"; whereas proportionately more women are either single or widowed. The greatest proportion of men are married, while the women are widowed.

GRAPH 24

MARITAL STATUS OF APPLICANTS



GRAPH 25

AGE OF APPLICANTS REFERRED TO A.P.S.

N=2496

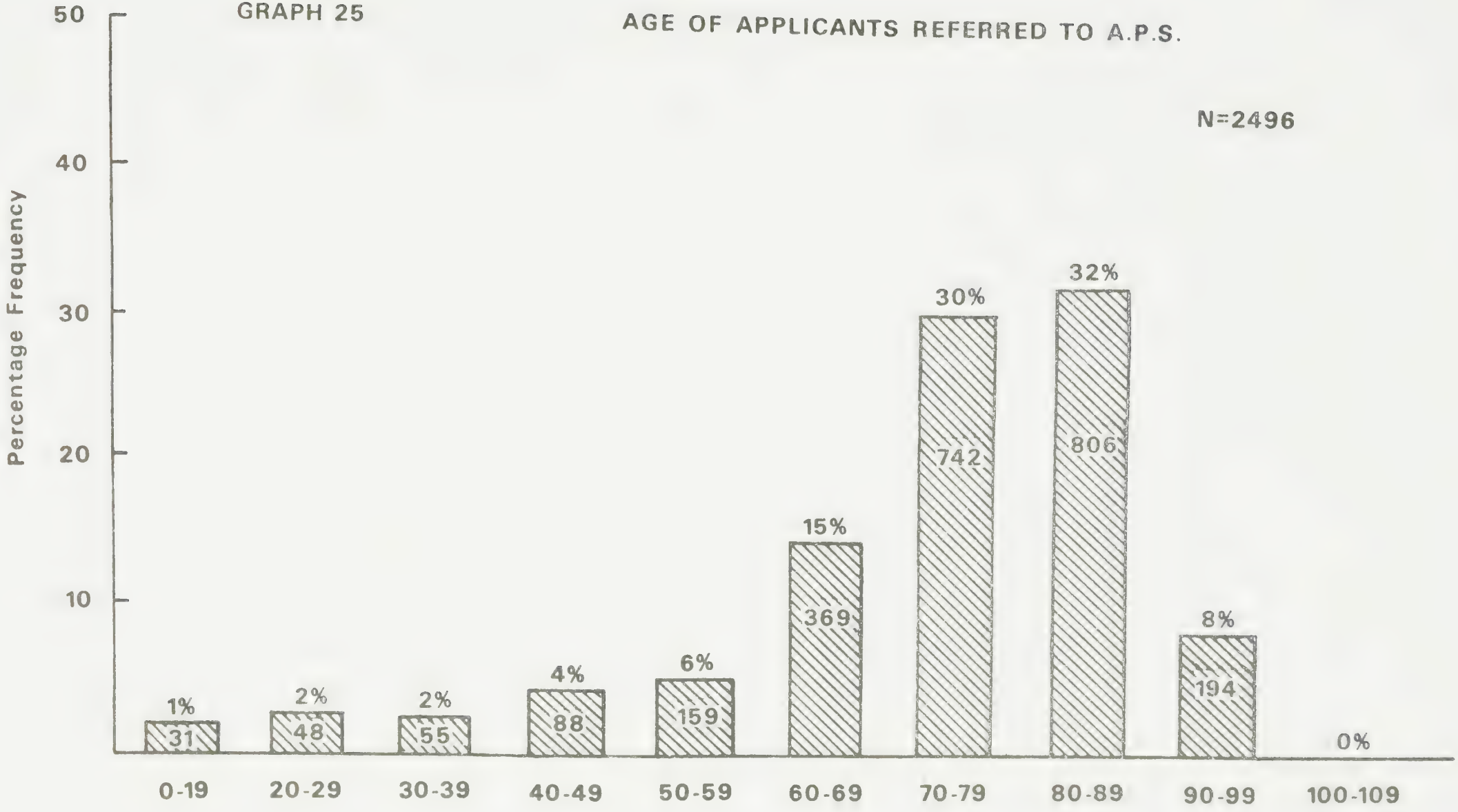


TABLE 8 SEX OF APPLICANTS BY MARITAL STATUS*

MARITAL STATUS	SEX		TOTAL
	Male	Female	
Married	358 (58) (39)	263 (42) (20)	621 (100) (27)
Single	185 (49) (20)	193 (51) (14)	378 (100) (17)
Divorced	33 (58) (4)	24 (42) (2)	57 (100) (3)
Separated	69 (60) (7)	46 (40) (3)	115 (100) (5)
Widowed	276 (26) (30)	804 (74) (60)	1080 (100) (48)
Other & Don't Know	6 (67) (1)	3 (33) (0)	9 (100) (0)
TOTAL	927 (41) (101)	1333 (59) (99)	2260 (100) (100)

N=2260 P $<$.001

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

In Table 9 one can see that from an approximately even proportion of males to females at age 60-69 the proportion of females increases as age increases. In the age group 70 and over, 74% are women and 63% are men.

Table 10 demonstrates the relationship between the age and marital status of the applicants to A.P.S. Sixty-four percent (64%) of the married applicants are seventy years of age or older, and 30% are over eighty. Eighty-nine percent (89%) of the widowed applicants are seventy or older, and 59% are over eighty. From the age of forty on, the proportion of married people in each category decreases as age increases. The proportion of widowed people, however, increases with age from 12% to 77%.

Only one percent (1%) of the A.P.S. applicants could not speak English. The breakdown of languages other than English understood by 322 applicants are as follows: Italian, 13%; German, 11%; French, 12%; Polish, 13%; other, 51%.

As Graph 26 shows, A.P.S. is dealing with a very impoverished segment of society: 70% of the applicants had a monthly income of $200 or less. Only 6% had a yearly income over $4,800. (i.e. - over $400 per month). Table 11 indicates the relationship between income and age. The highest proportion of each age group had an income of between $100 and $200 a month. The magnitude of that proportion increased with age though, from 35% at under 40 to 75% at 90 and over having $100 to $200 a month income. For each income group, except those with no income, the highest proportion (ranging from 50% to 68%) of the people were between 70 and 89 years of age. Fifty-two percent (52%) of those with no reported income were between 40 and 69 years of age.

With Whom Living

In terms of planning if an applicant might be able to return to or remain in his/her home, it is necessary to know with whom the applicant was living at the onset of the present episode. Graph 27 shows that 27% lived alone, 43% lived with spouse, children, or spouse and children, and 10% were already residing in an institution. If a person is able to return (or remain at) home, it is important to know if there is anybody able to assist the applicant in the activities of daily living. Graph 28 shows that 34% had no one to assist them and a further 4% had someone available but that person was not able to be of assistance to the applicant.

Table 12 demonstrates the relationship between with whom the applicant was living and if there was someone able to assist in A.D.L. Over half of those who

TABLE 9 SEX OF APPLICANTS BY AGE*

AGE	SEX		TOTAL
	Male	Female	
0-19	16 (2)	15 (1)	31 (1)
20-39	54 (5)	48 (3)	102 (4)
40-59	129 (13)	118 (8)	247 (10)
60-69	180 (17)	187 (13)	367 (15)
70-79	312 (30)	425 (29)	737 (30)
80-89	264 (26)	539 (37)	803 (32)
90+	77 (7)	121 (8)	198 (8)
TOTAL	1032 (100)	1453 (99)	2485 (100)

N=2485 P <.001

*( ) indicates column percentage

TABLE 10 AGE OF APPLICANTS BY MARITAL STATUS*

MARITAL STATUS	AGE						TOTAL
	0-39	40-59	60-69	70-79	80-89	90+	
Married	18 (3) (15)	98 (16) (42)	109 (18) (33)	213 (34) (32)	154 (25) (21)	29 (5) (16)	621 (101) (28)
Single	81 (21) (69)	61 (16) (26)	69 (18) (21)	93 (25) (14)	62 (16) (8)	11 (3) (6)	377 (99) (17)
Divorced	4 (7) (3)	18 (32) (8)	20 (35) (6)	9 (16) (1)	6 (11) (1)	0 (0) (0)	57 (101) (3)
Separated	13 (11) (11)	27 (23) (12)	37 (32) (11)	29 (25) (4)	9 (8) (1)	0 (0) (0)	115 (99) (5)
Widowed	0 (0) (0)	27 (3) (12)	91 (8) (28)	329 (30) (49)	497 (46) (68)	135 (13) (77)	1079 (100) (48)
Other & Don't Know	2 (22) (2)	0 (0) (0)	2 (22) (1)	2 (22) (0)	2 (22) (0)	1 (11) (1)	9 (99) (0)
TOTAL	118 (5) (100)	231 (10) (100)	328 (15) (100)	675 (30) (100)	730 (33) (99)	176 (8) (100)	2258 (101) (101)

N= 2258 P <.001

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

GRAPH 26

APPLICANTS' AMOUNT OF INCOME (PER MONTH)

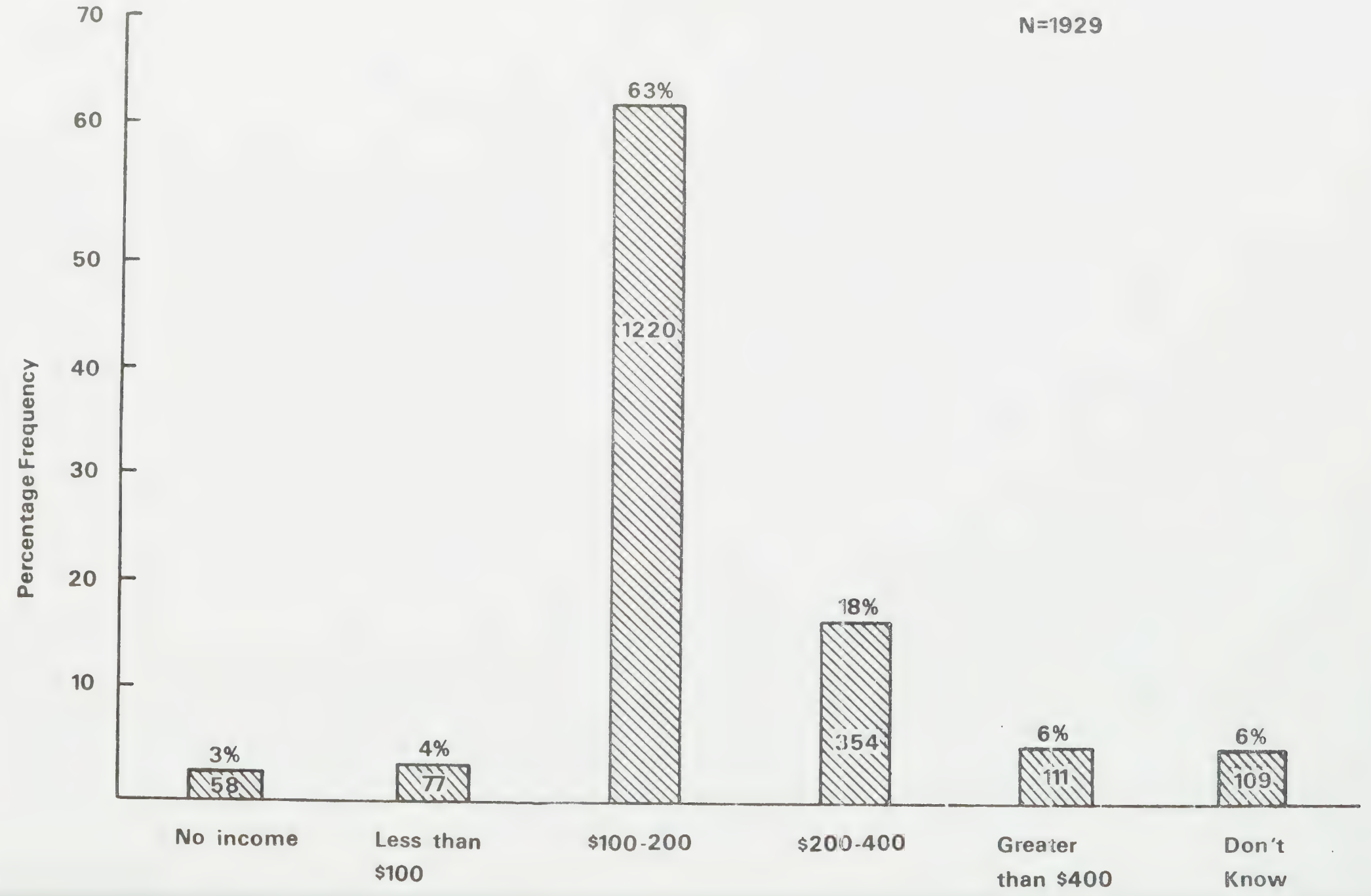


TABLE 11 APPLICANTS' MONTHLY INCOME BY AGE*

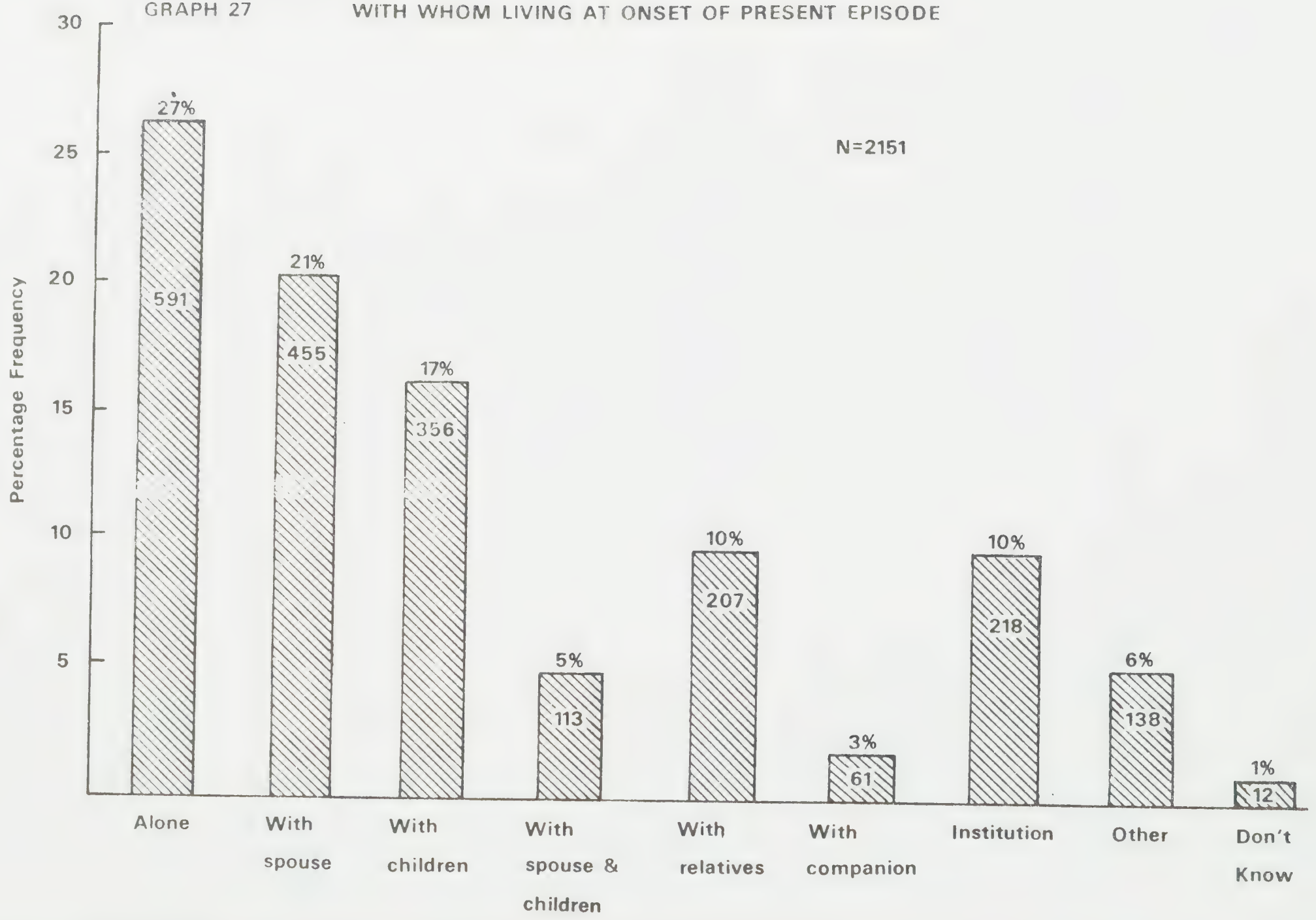
AGE	INCOME						TOTAL
	None	Less Than $100	$1-200	$2-400	Greater Than $400	Don't Know	
0-39	17 (22) (29)	8 (10) (10)	27 (35) (2)	6 (8) (2)	13 (17) (12)	6 (8) (6)	77 (100) (4)
40-59	18 (10) (31)	10 (6) (13)	91 (51) (7)	32 (18) (9)	16 (9) (14)	13 (7) (12)	180 (101) (9)
60-69	12 (4) (21)	16 (5) (21)	175 (58) (14)	58 (19) (16)	20 (7) (18)	20 (7) (19)	301 (100) (16)
70-79	7 (1) (12)	19 (3) (25)	390 (66) (32)	112 (19) (32)	32 (5) (29)	29 (5) (27)	589 (99) (31)
80-89	3 (0) (5)	19 (3) (25)	418 (67) (34)	126 (20) (36)	25 (4) (23)	32 (5) (30)	623 (99) (32)
90+	1 (1) (2)	5 (3) (6)	115 (75) (9)	20 (13) (6)	5 (3) (5)	7 (5) (7)	153 (100) (8)
TOTAL	58 (3) (100)	77 (4) (100)	1216 (63) (98)	354 (18) (101)	111 (6) (101)	107 (6) (101)	1923 (100) (100)

N=1923 $P < .001$

*top ( ) indicates row percentage

bottom ( ) indicates column percentage

GRAPH 27 WITH WHOM LIVING AT ONSET OF PRESENT EPISODE



GRAPH 28 IS THERE ANYONE TO ASSIST APPLICANT IN A.D.L.?

N=1884

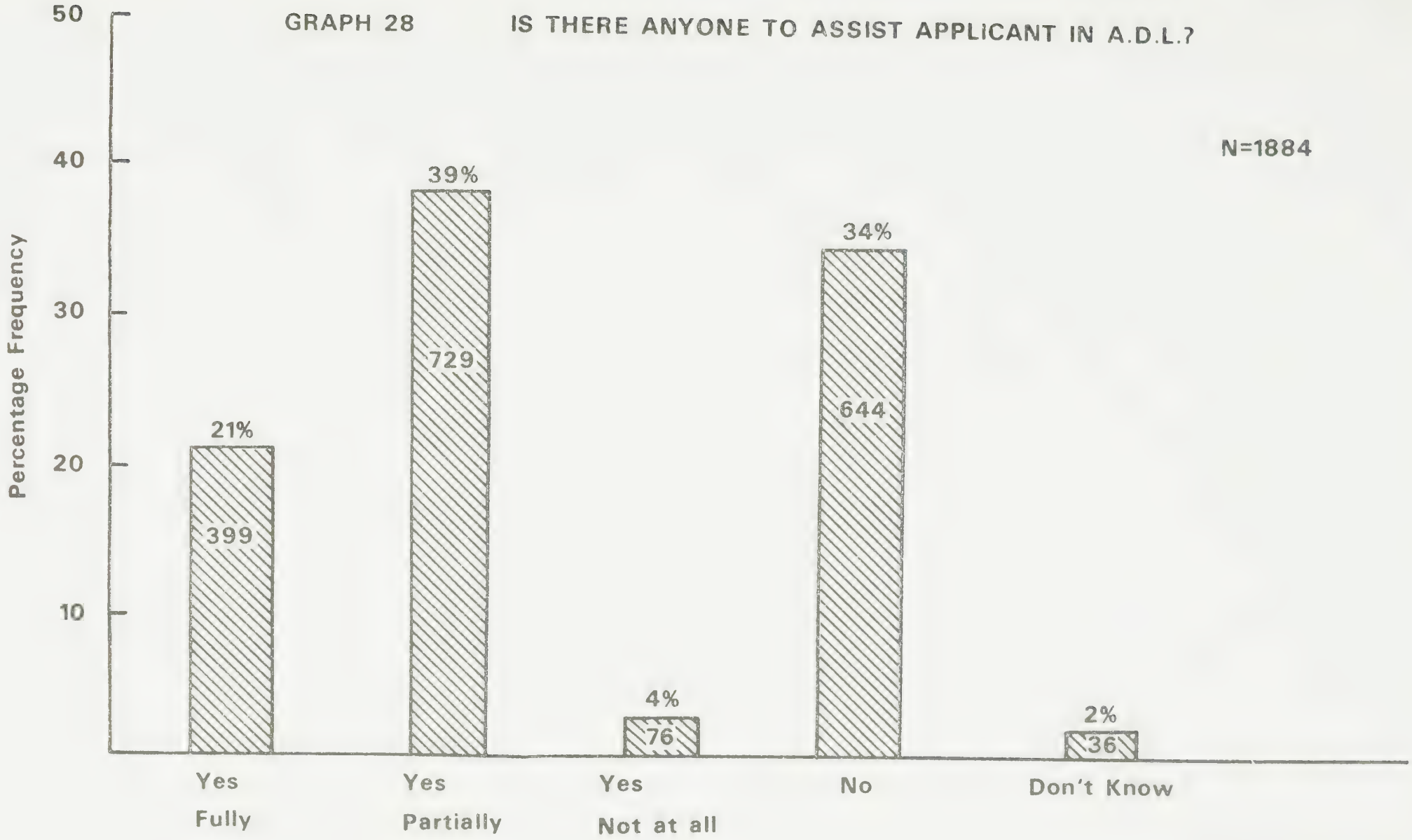


TABLE 12 WITH WHOM LIVING AT ONSET OF PRESENT EPISODE BY ANYONE ABLE TO ASSIST IN ADL*

ANYONE TO ASSIST IN A.D.L.	WITH WHOM LIVING AT ONSET OF PRESENT EPISODE								TOTAL
	Alone	With Spouse	With Children	With Spouse & Children	With Other Relat's	With Companion	In Institution	Other	
Yes-fully	20 (5) (4)	96 (25) (24)	91 (23) (30)	24 (6) (24)	55 (14) (31)	11 (3) (20)	64 (16) (50)	28 (7) (23)	389 (99) (21)
Yes-partially	124 (17) (22)	195 (27) (48)	160 (22) (51)	51 (7) (51)	90 (13) (50)	27 (4) (49)	28 (4) (22)	44 (6) (36)	719 (100) (39)
Yes-not at all	28 (37) (5)	14 (19) (3)	10 (13) (3)	2 (3) (2)	3 (4) (2)	4 (5) (7)	6 (8) (5)	8 (11) (7)	75 (100) (4)
No	377 (59) (68)	95 (15) (23)	44 (7) (14)	19 (3) (19)	29 (5) (16)	12 (2) (22)	25 (4) (20)	38 (6) (31)	639 (101) (34)
Other & Don't Know	6 (17) (1)	7 (19) (2)	6 (17) (2)	4 (11) (4)	3 (8) (2)	1 (3) (2)	4 (11) (3)	5 (14) (4)	36 (100) (2)
TOTAL	555 (30) (100)	407 (22) (100)	311 (17) (100)	100 (5) (100)	180 (10) (101)	55 (3) (100)	127 (7) (100)	123 (7) (101)	1858 (101) (100)

N=1858 $P < .001$

*top ( ) indicates row percentage

bottom ( ) indicates column percentage

had someone to assist, whether fully or partially, lived with their spouse, their children or both. Of those who reported that there was someone available but that the person was unable to assist them, 35% lived with spouse and/or children and 37% lived alone. Of those with no one to assist them 25% lived with spouse and/or children and 59% lived alone. For each living arrangement, the highest proportion of people had someone available, but only partially able to assist them, with the exception of those who lived in an institution (50% had someone able to fully assist) and those who lived alone (68% had no one to assist).

Brain Damage

There are two questions in the medical information section of the Referral Form rating the applicant's memory and orientation, and ability to be realistic in judgement. If an applicant was regarded as severely impaired in one or both of these areas, he/she was recorded as having a severe degree of brain damage, and similarly for moderate impairment. Graph 29 shows the degree of brain damage among the applicants: 83% are impaired to some degree. Table 13 outlines the relationship between degree of brain damage and location of final placement. Of those placed in each level of care, proportionately more were impaired, with the exception of those placed in chronic hospitals where proportionately more were severely impaired. The location of placement compared to degree of brain damage is as follows: of those with normal brain function, proportionately more were placed in chronic hospitals; impaired brain function, nursing homes; and severe brain damage, chronic hospitals.

Mood and Behaviour

The section on Mood and Behaviour in the Medical Information section of the Referral Form is coded in such a way as to indicate the degree of impairment in mood and behaviour. Graph 30 shows that only 16% were considered to be impaired. Table 14 shows the relationship between degree of impairment in mood and behaviour and the location of final placement. Regardless of the level of care of the placement, proportionately more people were regarded as normal in mood and behaviour. Of those who were impaired in mood and behaviour, 51% were placed in chronic hospitals and 32% in nursing homes.

GRAPH 29

DEGREE OF BRAIN DAMAGE

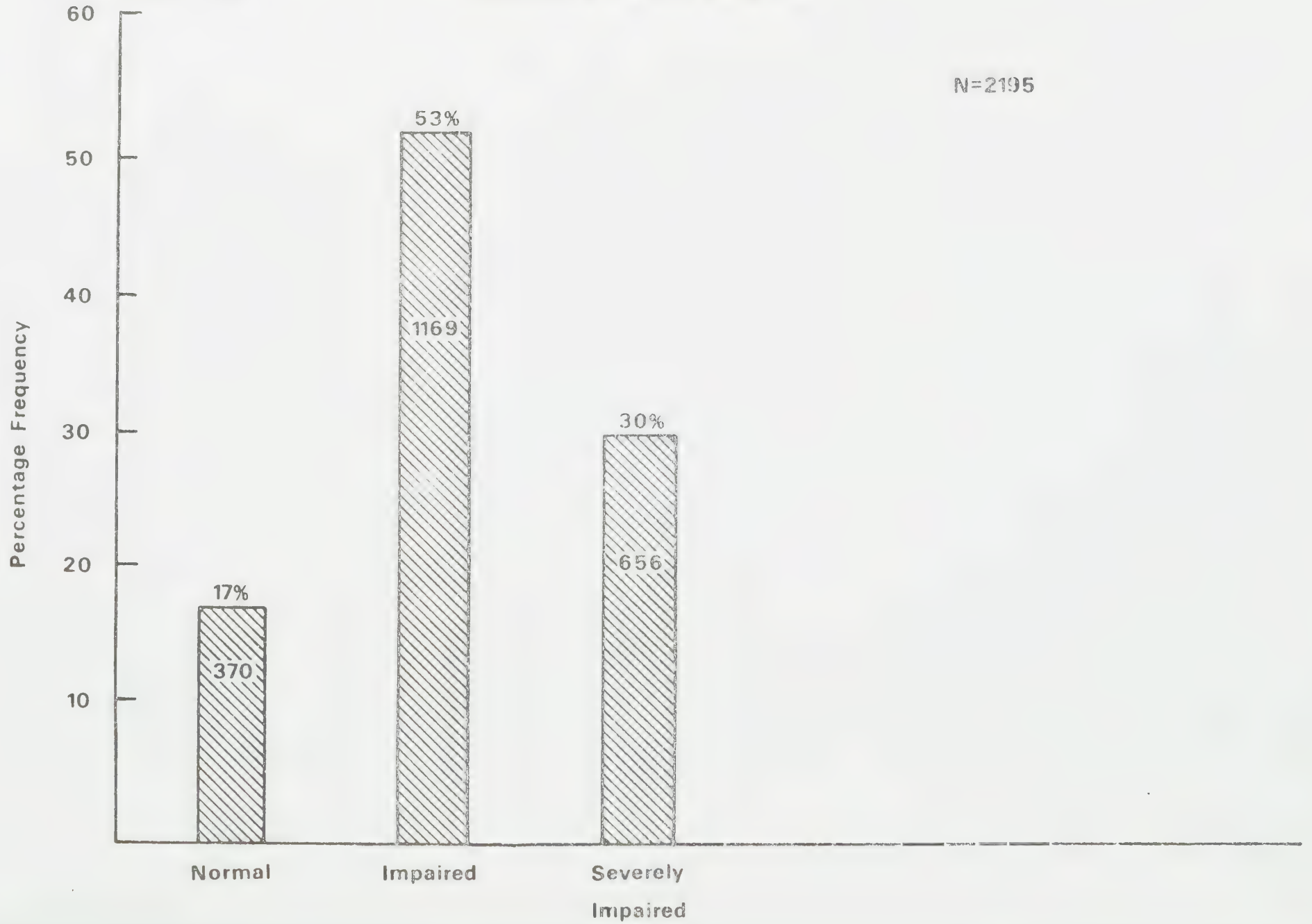


TABLE 13 APPLICANTS' DEGREE OF BRAIN DAMAGE BY LOCATION OF FINAL PLACEMENT*

LOCATION OF FINAL PLACEMENT	DEGREE OF BRAIN DAMAGE			TOTAL
	Normal	Impaired	Severely Impaired	
Rehab** Facility	36 (38) (17)	49 (52) (8)	10 (11) (3)	95 (101) (8)
Chronic Hospital	59 (15) (28)	161 (40) (25)	186 (46) (51)	406 (101) (33)
Nursing Home	47 (11) (22)	251 (59) (39)	128 (30) (35)	426 (100) (35)
Home for the Aged	15 (18) (7)	50 (60) (8)	18 (22) (5)	83 (100) (7)
Lodging House	14 (19) (7)	56 (75) (9)	5 (7) (1)	75 (101) (6)
Support Services***	39 (30) (19)	76 (58) (12)	15 (12) (4)	130 (100) (11)
TOTAL	210 (17) (100)	643 (53) (101)	362 (30) (99)	1215 (100) (100)

N=1215 $P < .001$

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

**Acute & Psychiatric Hospital(s) are included in this level of care grouping but the numbers are minimal

***Includes no services

GRAPH 30 DEGREE OF IMPAIRMENT IN MOOD AND BEHAVIOUR

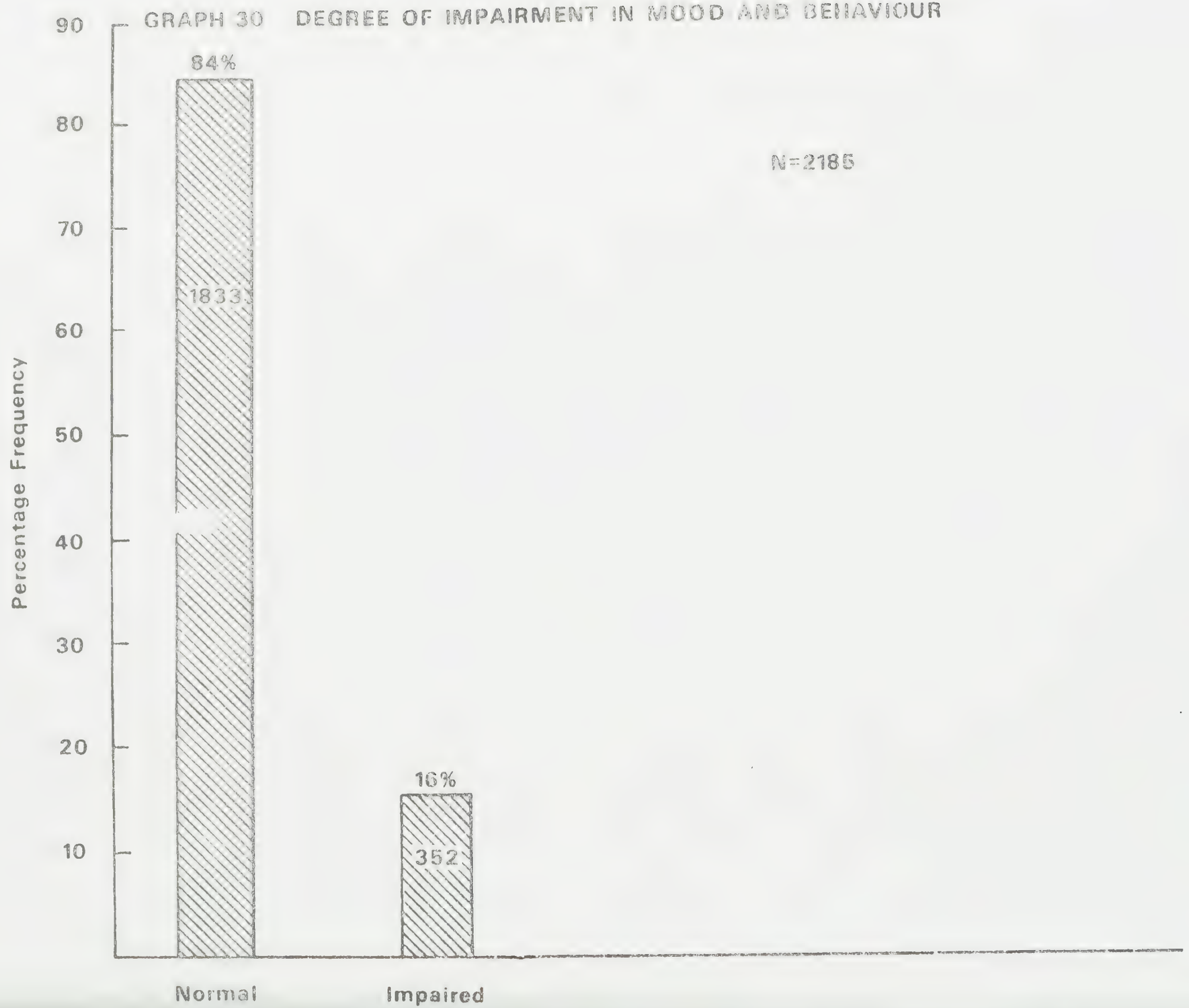


TABLE 14 APPLICANTS' DEGREE OF MOOD IMPAIRMENT BY LOCATION OF FINAL PLACEMENT*

LOCATION OF FINAL PLACEMENT	MOOD		TOTAL
	Normal	Impaired	
Rehab Facility**	91 (96) (9)	4 (4) (2)	95 (100) (8)
Chronic Hospital	307 (76) (30)	98 (24) (51)	405 (100) (33)
Nursing Home	366 (86) (36)	61 (14) (32)	427 (100) (35)
Home for the Aged	71 (86) (7)	12 (14) (6)	83 (100) (7)
Lodging House	70 (95) (7)	5 (5) (2)	74 (100) (6)
Support Services***	117 (89) (11)	14 (11) (7)	131 (100) (11)
TOTAL	1022(84) (100)	193 (16) (100)	1215(100) (100)

N=1215 P <.001

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

**Acute & Psychiatric Hospital(s) are included in this level of care grouping but the numbers are minimal

***Includes return home with no services

Activities of Daily Living

The Social-Nursing section of the Referral Form contains a section enquiring about the applicant's Functional Capacity, in Communication and Self-Maintenance. An index of the applicant's ability to function in the activities of daily living (ADL) was devised and includes the following categories of ability: to be understood by others - in own language; to express self - by words or gestures; to comprehend present life situation and future - in own language; to use toilet; to feed; to dress; to groom; to bathe; and to ambulate. Graph 31 outlines the ability of the A.P.S. applicants ability to function in A.D.L.: 95% have some degree of impairment.

Table 15 outlines the relationship between the applicants' ability to function in A.D.L. with the degree of brain damage. Looking at the numbers in each cell relative to the total, the following should be noted: 25% are impaired in both ADL and brain functioning; 25% are impaired in brain functioning and severely impaired and in ADL functioning; and a further 25% are severely impaired in both.

Table 16 compares the applicants' ability to function in ADL with the location of final placement. Of those who were placed in each level of care, proportionately more of the severely impaired were placed in rehabilitation, and chronic facilities and nursing homes, while proportionately more of the impaired were placed in homes for the Aged, lodging houses, and special living facilities. Of those who were normal in ADL, proportionately more were placed in lodging houses and special living facilities even though the largest proportion had been recommended for a placement in a Homes for the Aged. Proportionately more of those who were impaired in ADL were placed in nursing homes, while the severely impaired were placed in chronic hospitals.

Other Characteristics

The attending physicians were asked to record on the Referral Form if their patient would require an indwelling catheter in the near future. In 14% of the cases where this section of the form was completed, it was anticipated that an indwelling catheter would be required.

GRAPH 31

ABILITY TO FUNCTION IN ACTIVITIES OF DAILY LIVING

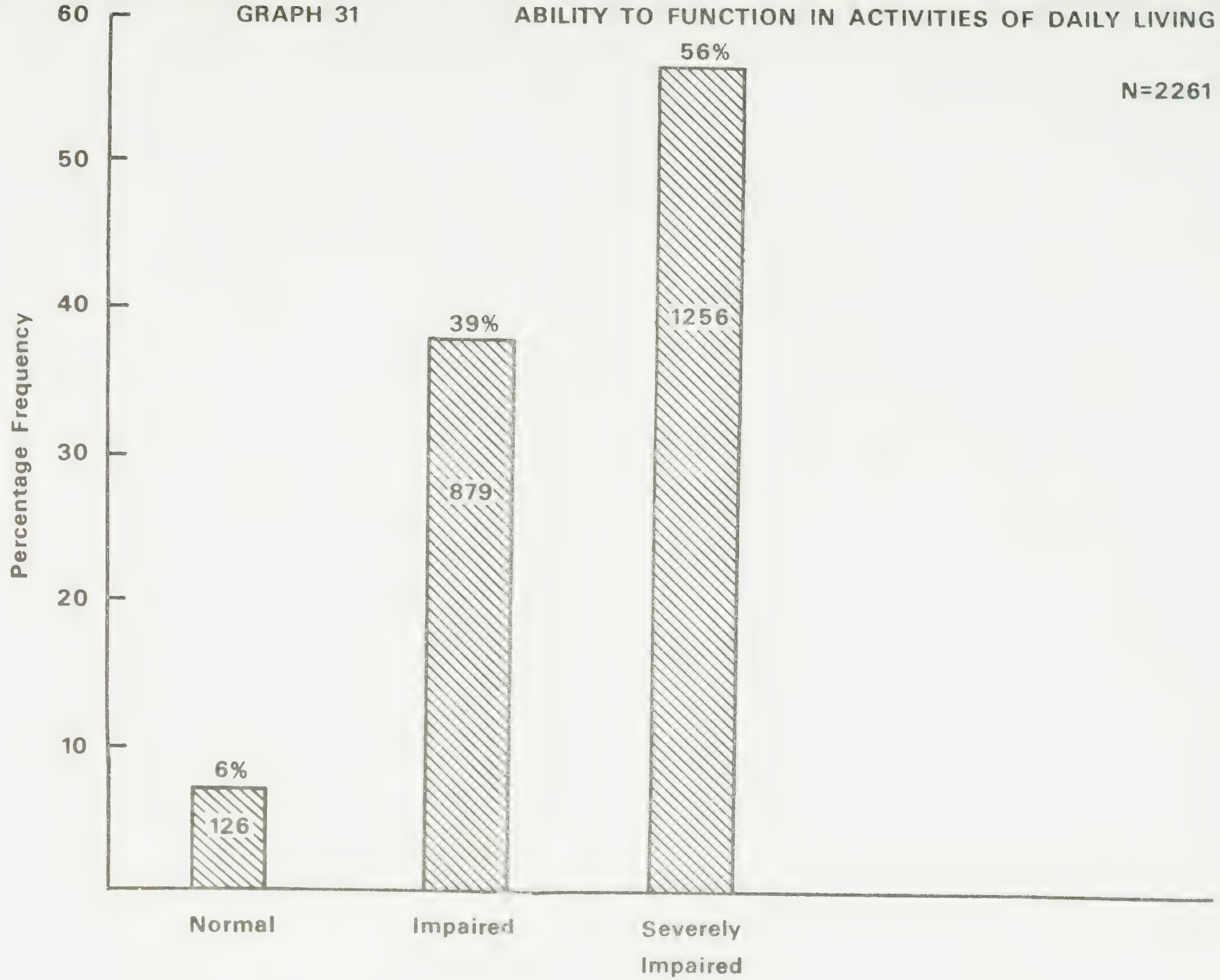


TABLE 15 APPLICANTS' ABILITY TO FUNCTION IN A.D.L. BY DEGREE OF BRAIN DAMAGE*

DEGREE OF BRAIN DAMAGE	ABILITY TO FUNCTION IN ADL			TOTAL
	Normal	Impaired	Severely Impaired	
Normal	50 (2)	196 (9)	113 (5)	359 (17)
Impaired	59 (3)	529 (25)	537 (25)	1125 (53)
Severely Impaired	5 (0)	98 (5)	539 (25)	642 (30)
TOTAL	114 (5)	823 (39)	1189 (56)	2126 (100)

N=2126 P <.001

* ( ) indicates percentage of the total

TABLE 16 APPLICANTS' ABILITY TO FUNCTION IN ADL BY LOCATION OF FINAL PLACEMENT*

LOCATION OF FINAL PLACEMENT	A.D.L.			TOTAL
	Normal	Impaired	Severely Impaired	
Rehab Facility**	5 (5) (10)	44 (45) (10)	48 (49) (7)	97 (99) (8)
Chronic Hospital	4 (1) (8)	59 (14) (13)	353 (85) (48)	416 (100) (33)
Nursing Home	3 (1) (6)	162 (38) (36)	265 (62) (36)	430 (101) (35)
Home for the Aged	9 (11) (19)	52 (63) (11)	22 (27) (3)	83 (101) (7)
Lodging House	17 (22) (35)	53 (70) (12)	6 (8) (1)	76 (100) (6)
Support Services***	10 (8) (21)	84 (64) (19)	37 (28) (5)	131 (100) (11)
TOTAL	48 (4) (99)	454 (37) (101)	731 (59) (100)	1233 (100) (100)

N=1233 P <.001

*top ( ) indicates row percentage
bottom ( ) indicates column percentage

**Acute & Psychiatric Hospital(s) are included in this level of care grouping but the numbers are minimal

***Also includes return Home with no services

The applicant's ability to see was recorded: 2%, or 34 people, can distinguish only light and dark; and 1%, or 21 people, were recorded as being totally blind. The C.N.I.B. presently have record of approximately 100 people in Wentworth county who are either totally blind or who have only light and dark perception.

One of the categories in the Functional Capacity - Self Maintenance section of the Referral Form was ambulation. This is an important factor to consider in placement. Graph 32 outlines the degree of ambulation: 35% are either chair or bed-ridden.

The attending physicians are asked to list all the medical diagnoses of an applicant in order of importance, on the A.P.S. Referral Form. The physicians' information was specially coded by the Medical Director of A.P.S. Specific information regarding coding is listed in the appendix. Primary and Secondary diagnoses were defined to be the diseases which were the two most important ones to consider in making placement (i.e. - the ones that will most definitely benefit by placement, either through prevention of breakdown or improvement). Where two diagnoses were of equal importance in the above regard, the disease which was most life threatening would be coded as the primary diagnosis. In coding the secondary diagnosis preference would be given to a diagnosis unassociated with the primary one. Table 17 lists the twelve primary and secondary diagnoses that occurred with the greatest frequency in the A.P.S. population. It will be noted that there is considerable difference between the highest ranking primary and secondary diagnoses.

Final Comments

The information collected by A.P.S. can be used to facilitate rational planning in the extended health care field. A.P.S. is able to describe, in detail, the needs and characteristics of the chronically ill population in Hamilton district. If a new program was being proposed that was designed to meet specific needs, A.P.S. would be able to state the number and characteristics of the target population that had been identified in the previous year(s). In this way, an appropriate number of beds could be alloted to all district programs to ensure the optimal utilization of facilities. By collecting this data, we are given the opportunity to serve the population of Hamilton district in a more humane as well as efficient manner, and reduce the cost of health care by planning facilities and programs that match the needs of the people.

GRAPH 32

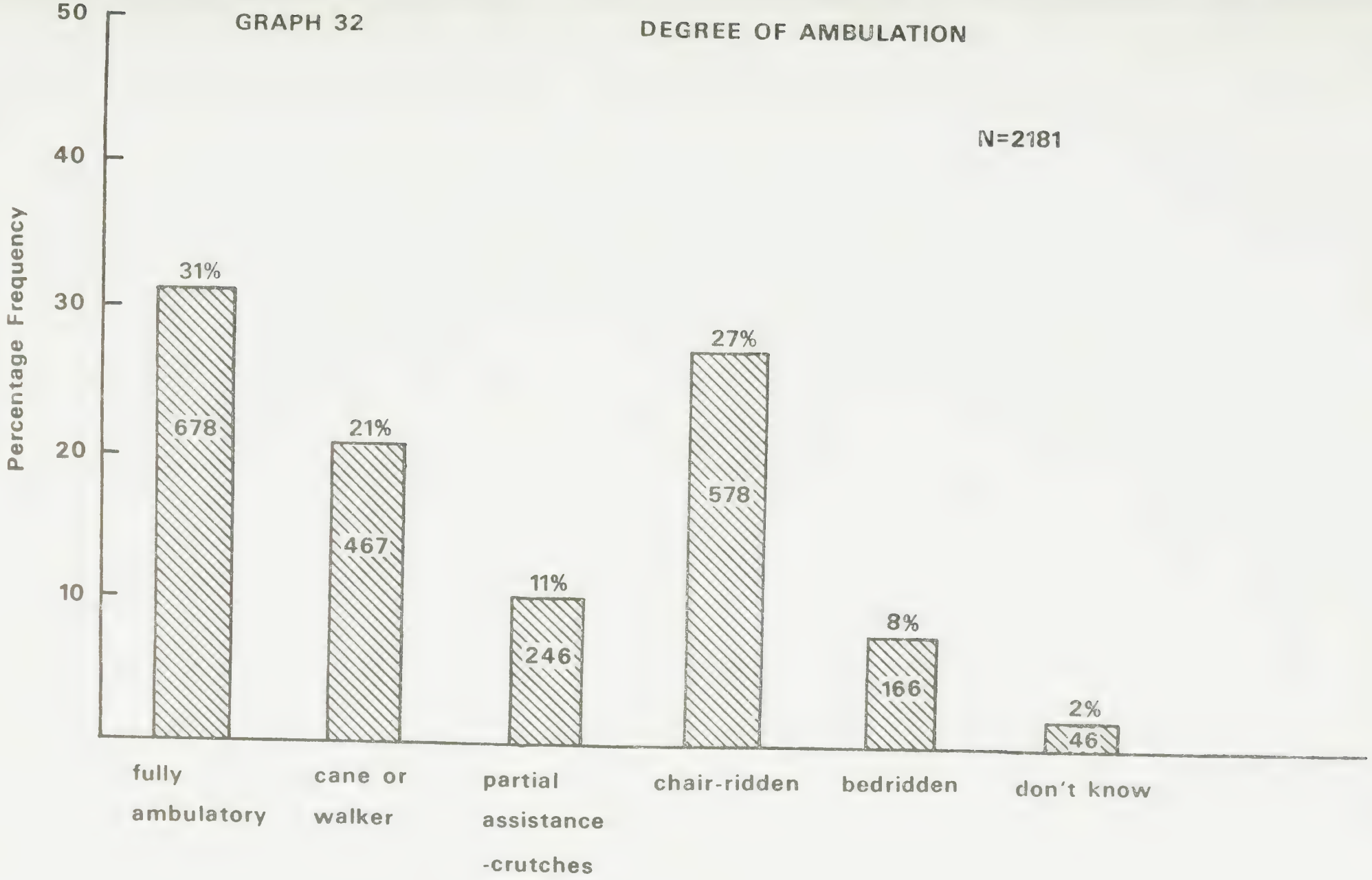

DEGREE OF AMBULATION
N=2181
Percentage Frequency
50
40
30
20
10
31%
678
21%
467
11%
246
27%
578
8%
166
2%
46
fully ambulatory
cane or walker
partial assistance -crutches
chair-ridden
bedridden
don't know

TABLE 17 PRIMARY & SECONDARY DIAGNOSES *

Rank	Primary Diagnosis	N.	%	Secondary Diagnosis	N.	%
1	Psychosis due to arteriosclerosis	307	14	Ischaemic Heart Disease	184	11
2	Cerebrovascular disorders (incl sub arachnoid haem)	253	12	Arthritis,rheumatism,all Musculo Skeletal Disorders	172	10
3	Senile & presenile dementia	165	8	Diabetes Mellitus	136	8
4	Fractured lower limb	163	7	Other Heart Diseases	96	6
5	Arthritis,rheumatism all Musculo Skeletal Disorders	155	7	Respiratory diseases	86	5
6	Ischaemic Heart Disease	138	6	Digestive tract (excl liver)	75	5
7	Diseases of the Nervous System (incl hemiplegia,paraplegia, non vascular,non traumatic)	88	4	Hypertensive Disease	65	4
8	Respiratory Diseases	65	3	Disease-arteries,veins,lymphatics	62	4
9	Other Heart Diseases	58	3	Senile & presenile dementia	56	3
10	Disease-arteries,veins,lymphatics	53	2	Eye condition (all types)	50	3
11	Psychosis due to undetermined organic cause	49	2	Diseases of skin	48	3
12	Neoplasms of digestive system	47	2	Neuroses (anxiety and depression)	46	3
	The first 12 Primary Diagnoses represent 70% of all Primary Diagnoses reported (N=2193)			The first 12 Secondary Diagnoses represents 65% of all Secondary Diagnoses reported (N=1643)		

* (SEE APPENDIX D)

APPENDIX A:

CODING DEFINITIONS

An 18 page abstracting form,"A.P.S. Data Sheet - 1972-73" was used to code information obtained from the A.P.S. Referral Form and the office Action Sheet. Most of the information was abstracted directly from the Referral Form to the Data Sheet, however, some of the 75 variables required some interpretation prior to coding. The variables listed here required definition to ensure uniform coding. The Referral Form and Data Sheet are available upon request.

Referral Form Number: - the number of times the referral process has beeninitiated for an applicant to A.P.S. between September 1, 1972 and August 31, 1973. A "9" indicates the case was carried over from last year, that is - referred in the 71-72 coding year.

Type of Service: - 6 categories of service

1) Referral - No Contact: person has not been formally referred to A.P.S. but we have been given the person's name. This includes such cases as those where an institution gives us the name of a person who has applied to an extended care facility, without going through A.P.S., and has been refused admission. We have not been asked to provide a service though.

2) Brief Service: person has been formally referred to A.P.S., an Action Form has been initiated and perhaps the Referral Form has been mailed out for completion. No forms have, as yet, been returned. Case may still be active, or may be closed.

3) Partial Assessment: person has been formally referred to A.P.S., an Action Form has been initiated and either the Social-Nursing section or the Medical section of the Referral Form has not, as yet, been completed and returned. The case may still be active or may be closed.

4) Complete Assessment: person has been formally referred to A.P.S., an Action Form has been initiated, and the complete Referral Form has been returned to the A.P.S. office. The case may still be active or may be closed.

5) For Statistics Only: person was placed before completed assessment was received at the A.P.S. office.

6) Previously Coded: the case was previously coded for the 1971-72 Report. The completed referral form and any placement activity that occurred before September 1, 1972 was coded. This is used to record any recommendations, placements or deaths that occurred in these cases in the 72-73 coding year. (If part or all of a Referral Form was received in this coding year on a case that was referred in the past coding year, only the action from September 1, 1972 was recorded. E.G. - Medical section received August 30, 1972, Social-Nursing section received September 5, 1972: Type of Service would be recorded as "Partial Assessment", Referral Number would be "9" and any action with regard to recommendations, placement or death would be recorded. Only the information from the Social-Nursing section of the Form would be coded).

Location (i.e. - Level of Care) at:

Time of Contact: the level of care of the facility or program at which the applicant was located, at the time of contact (i.e. - when referral process was initiated). See the Health Care Facility Code List - Appendix B.

Location (i.e. Level of Care) of the:

"Final Placement" Recommendation: the level of care of the facility or program which the A.P.S. consultants recommended for the location of the "final placement" of the applicant. "Final placement" is taken as the location where it is recommended the person remain for a prolonged period of time. For example: If it is recommended that a person who needs physiotherapy for a short time should therefore go to a rehabiliation unit for a few weeks and then be placed in a nursing home, the rehabilitation unit would be an intermediate placement recommendation and the nursing home would be a final placement recommendation. See the Health Care Facility Code List - Appendix B.

Location (i.e. Level of Care) of the:

"Final Placement": If the person was, in fact, placed at the level of care recommended as the "final placement", the date of placement was recorded. If the person was not placed, 9's were recorded. By means of a boolean restriction, the cases that were in fact placed at the recommended location can be identified. See the Health Care Facility Code List - Appendix B.

Location (i.e. Level of Care):

Just Prior to Final Placement: the level of care of the facility or program at which the applicant was located, just prior to his/her final placement. This can be taken as an indication of where the person was waiting for his/her placement to be effected. See the Health Care Facility Code List - Appendix B.

First Intermediate Placement: the level of care of the facility or program at which the applicant was placed -- which was eighter the first placement prior to, or instead of the "final placement" This may or may not have been recommended by A.P.S. See the Health Care Facility Code List - Appendix B.

Location (i.e. Level of Care):

Just Prior to Placement: the level of care of the facility or program at which the applicant was located, just prior to his/her first intermediate placement. See the Health Care Facility Code List - Appendix B.

Second, Third and/or Fourth Intermediate Placement: the level of care of the facility or program at which the applicant was placed at the 2nd, 3rd and/or 4th intermediate placement - i.e. - a placement prior to or instead of the "final placement". These placements may or may not have been recommended by A.P.S. See the Health Care Facility Code List - Appendix B.

Subsequent Placement - First and/or Second: the level of care of the facility or program at which the applicant was placed following or subsequent to, the final placement. The case would not have been re-referred, but a continuation of a case that had not been closed as yet. Example: An elderly man may have been placed (final placement) in a nursing home and it was later decided that the daughter-in-law would take care of the man at home. Home would be recorded as the first subsequent placement. These may or may not be recommended by A.P.S. See Health Care Facility Code List - Appendix B.

Satisfaction with Placement: refers to the A.P.S. satisfaction with a placement, taking into consideration the institutions, facilities and programs as they presently exist. The judgement is based on a

follow-up (by telephone usually) carried out one month later,after a person's placement. A.P.S. might conceivably consider a certain placement generally unsatisfactory on the basis that the person's needs are not being met adequately, according to our information, while the patient themselves may be quite happy with the placement. The satisfaction is in terms of the final placement(and there are no subsequent placements), the last intermediate placement in the event that the final placement has not yet occurred, or the last subsequent placement, if there is one. See the Coding Categories for "Satisfaction with Placement" - Appendix C.

Area Serviced by A.P.S.:

From the home address of the applicant as recorded on the Referral Form the area in which he/she resided was determined. A person was recorded as living within the area served by the Hamilton District Health Council if she/he lived in or around the following communities: Hamilton or Ancaster, Beamsville, Binbrook, Burlington, Caledonia, Dundas, Freelton, Grimsby, Lynden, Mount Hope, Stoney Creek, Vineland, Waterdown, West Lincoln, Winona.

Brain Damage:

See questions 1 and 2 (Memory and Orientation and Ability to be realistic in judgement) under Psychological Functioning in the Medical section of the Referral Form. These two questions were grouped in such a way as to yield three categories of brain damage: no brain damage (normal), impaired, severely impaired.

Mood and Behaviour:

See question 3 (a) to (f) (Mood and Behaviour, Mood, Participation, Cooperation) under Psychological Functioning in the Medical section of the Referral Form. This question was grouped in such a way as to yeild two categories of mood and behaviour impairment: no functional psychological impairment, and functional psychological impairment.

Activities of Daily Living:

See questions 3, 4, and 5 under Communication (Ability to be understood by others in own language; Ability to express self by words or gestures; and Ability to comprehend present life situation and future) and questions 1 to 7 inclusive under Self-Maintenance (Ability to use toilet; to feed; to dress; to groom;

to bathe; Bed care; and Ambulation) in the Functional Capacity section (in the Social Nursing part) of the Referral Form. These questions were grouped in such a way as to give three categories of ability to function in activities of daily living (ADL): no problems, impaired, severely impaired.

Primary & Secondary Diagnoses: (coded by the Medical Director of A.P.S.):

In coding the medical diagnosis, the physician's diagnosis on the referral form was categorized according to a classification based on the International Diagnostic Code - Adapted listing 61 classes. "Psychosis due to arteriosclerosis" included dementias listed as "cerebral arteriosclerosis" and "cerebrovascular insufficiency". "Cerebrovascular disorders" included stroke due to various types of vascular lesions. Senile & Presenile dementia include the dementias the physician labelled as "senile". It must be realized it is not always possible to differentiate between arteriosclerotic and senile dementia and the reliability of these categories is therefore doubtful. The category "Diseases of the Nervous System" included hemiplegia if this was not stated as due to vascular disease.
A diagnosis was considered "primary" when it was the most important one to consider in making a recommendation for placement either in causing placement to be required or as the condition that would be improved or stabilized by the placement recommended. When two diagnoses were equally important in this regard, the one that was more serious as a threat to life was considered primary.
A diagnosis was considered "secondary" when it was second in importance to consider in recommending placement. A diagnosis closely associated with the primary diagnosis and causally linked was not chosen as "secondary" unless no other condition was listed that contributed to placement. See Appendix D - Primary and Secondary Diagnoses.

Length of Time in Process - Calculations:

The dates of certain events in the process of assessing and placing applicants to A.P.S. were recorded: date of contact; date of completed referral form being received at A.P.S.; date that the first recommendation was made (i.e. - the case may have been re-conferenced at a later date due to new information, but only the date the case was first conferended would be recorded);

date that the applicant was placed in the location of the "final placement" recommendation; date of the first intermediate placement. In calculating the time between certain events, weekends and holidays were counted as days waiting. The length of time between the following events was calculated: contact and receipt of the form; receipt of the form and recommendations being made; recommendations being made and intermediate/final placements; intermediate and final placements; contact and intermediate/final placements.

APPENDIX B:

HEALTH CARE FACILITY CODE LIST*

- FOR 1972 to 1973 -

Acute Care Hospitals
- Chedoke Hospitals (+ Mountain San)..... 01
- Hamilton General Hospital..... 02
- Henderson General Hospital..... 03
- St. Joseph's Hospital..... 04
- Joseph Brant Memorial Hospital..... 05
- M.U.M.C..... 06
- Other Hospital..... 07

Psychiatric Hospital or unit:
- acute care..... 08
- extended care (M.R. homes - Cedar Springs). 09

Special Rehab Unit..... 10

General Rehab Unit 11

Chronic Hospital..... 12

Nursing Home..... 13

Home for the Aged: bed care 14
" " " special care 15
" " " normal care 16

Lodging House..... 17

Special Living Facilities 18

Support Services 19

Other: Day Centre/ Homes for Special Care/ Lodging House/ Community Psych Team, etc..... 20

Home..... 21

Don't Know 88

Not Answered..... 99

* It is recognized that some of these terms are not well defined but are utilized here because of common usage locally.

APPENDIX C :

CODING CATEGORIES FOR "SATISFACTION WITH PLACEMENT":

- FOR 1972 to 1973 -

Code for final placement if it has occurred, or the last intermediate placement in the event final placement has not yet occurred.

1. Generally Satisfactory

a - nothing listed as being unsatisfactory..... 01
b - a long wait was involved
(i) due to lack of appropriate beds..... 02
(ii) due to other problems (eg. family and/ or patient didn't like suggested placement facilities) 03
c - family and/or patient didn't like actual placement facility..... 04
d - inappropriate placement
(i) assessment incorrect..... 05
(ii) placed without A.P.S..... 06
(iii) facility couldn't handle/didn't wish to keep patient..... 07
(iv) didn't work out very well for other/or unknown reasons..... 08
e - patient placed before recommendations made..... 09
f - patient/family/referring facility refused recommendations..... 10
g - other..... 11

2. Generally Unsatisfactory

a - no reasons stated..... 12
b - a long wait was involved
(i) due to lack of appropriate beds..... 13
(ii) due to other problems (eg. family and/or patient didn't like suggested placement facilities) 14
c - family and/or patient didn't like actual placement facility..... 15
d - inappropriate placement
(i) assessment incorrect..... 16
(ii) placement without A.P.S..... 17
(iii) facility couldn't handle/ didn't wish to keep patient..... 18
(iv) didn't work out very well for other/or unknown reasons..... 19
e - patient placed before recommendations made..... 20
f - patient/family/referring facility refused recommendations..... 21
g - other..... 22
h - patient died within two weeks of placement..... 23

3. Don't Know..... 88

4. Not Answered..... 99

APPENDIX D :

- PRIMARY & SECONDARY DIAGNOSIS -

- FOR 1972 to 1973 -

01 Infectious and Parasitic (Except TB and late effects of Polio)

02 Tuberculosis

03 Late Effects of Polio

04 Neoplasms - Buccal and Pharynx

05 " " - Digestive

06 " " - Respiratory

07 " " - Bone,skin, breast

08 " " - G-U

09 " " - Other sites

10 " " - Lymphatic & Haemo

11 " " - Benign

12 " " - Unspecified

13 Thyroid Disorders

14 Other Endocrine (except Thyroid & Diabetes Mellitus)

15 Diabetes Mellitus

16 Nutritional Deficiencies (incl. obesity)

17 Other Metabolic

18 Disease Blood

19 Senile & Pre Senile Dementia

20 Alcoholic Psychosis

21 Psychosis - due to arteriosclerosis (cerebral arteriosclerosis, cerebrovascular insuff.)

22 Psychosis due to undetermined organic cause or trauma

23 Psychosis - non cerebral physical condition

24 Schizophrenia

25 Affective Psychosis

26 Paranoid

27 Other Psychosis

28 Neuroses (Anxiety and Depression)

29 Personality disorders

30 Alcoholism

31 Other drug dependence

32 Other non psychotic Mental Disorders

33 Mental Retardation

34 Diseases of Nervous System (incl. hemiplegia, paraplegia, non vascular, non traumatic or not specified)

35 Multiple Sclerosis

36 Parkinsonism

37 Cerebral spastic infantile paralysis

38 Epilepsy

39 Moter Neurone Disease

40 Disease of Peripheral Nerves

41 Eye Condition (all types)

42 Ear Condition (all types)

43 Rheumatic Heart Disease

44 Hypertensive Disease

45 Ischaemic Heart Disease

46 Other Heart Diseases (or not specified)

47 Cerebrovascular Disorder (including subarachnoid haem, stroke, C.V.A.)

APPENDIX D: cont'd

48 Disease Arteries, Veins, Lymphatics

49 Respiratory Diseases

50 Digestive Tract excl liver

51 Disease liver, gall bladder and bile ducts

52 Diseases GU (non neoplastic)

53 Diseases of Skin

54 Arthritis, Rheumatism all Musculo Skeletal Disorders

55 Congenital

56 Senility without psychosis

57 Fracture Skull, spine and trunk

58 Fracture upper limb

59 Fracture lower limb (if not weight bearing - if so then 54)

60 Other injuries and accidents

61 Traumatic Paraplegia and Quadriplegia

URBAN/